

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05532

05526

To HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
				Sidney	N.M.I.	Alexander	Month	Day	Year	IF UNDER 1 YEAR	IF UNDER 24 HRS	
3. SEX				4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		7. ADDRESS			
Male				White	5-13-84		84 yrs.		MONTHS	DAYS	HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input checked="" type="checkbox"/>	DIVORCED	<input type="checkbox"/>	9. COUNTY OF DEATH
Wash., D.C.		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Montgomery
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Potomac Valley Nursing Home				Auto DEALER			AUTO			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
Maryland		Montgomery		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8417 FOX RUN						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
NO		—		220-03-0225 ROGER ALEXANDER - SAME AS # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Pulmonary Fibrosis & Emphysema												
DUE TO, OR AS A CONSEQUENCE OF												
517X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
Alveo Parkinsons Disease, Urinary Retention												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Arterosclerotic Heart Disease, Generalized Arterosclerosis, suprarenal												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.		19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 4/16/69, 19, to 4/27/69, 19, that (we) last saw the deceased alive on 4/27/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		22c. DATE SIGNED		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.				
Frederick S. Colburn, M.D.		4-27-69		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		Falls Church, Va.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)		
BURIAL		4-29-69		NATIONAL MEMORIAL CEM.		FALLS CHURCH, VA.						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Jos. GAWLER'S Sons, 5130 WISCONSIN AVE., WASHINGTON, D.C.		MAY 2 1969				Charles Judge						

200



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. In any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm Page 5 may be retained for your files.

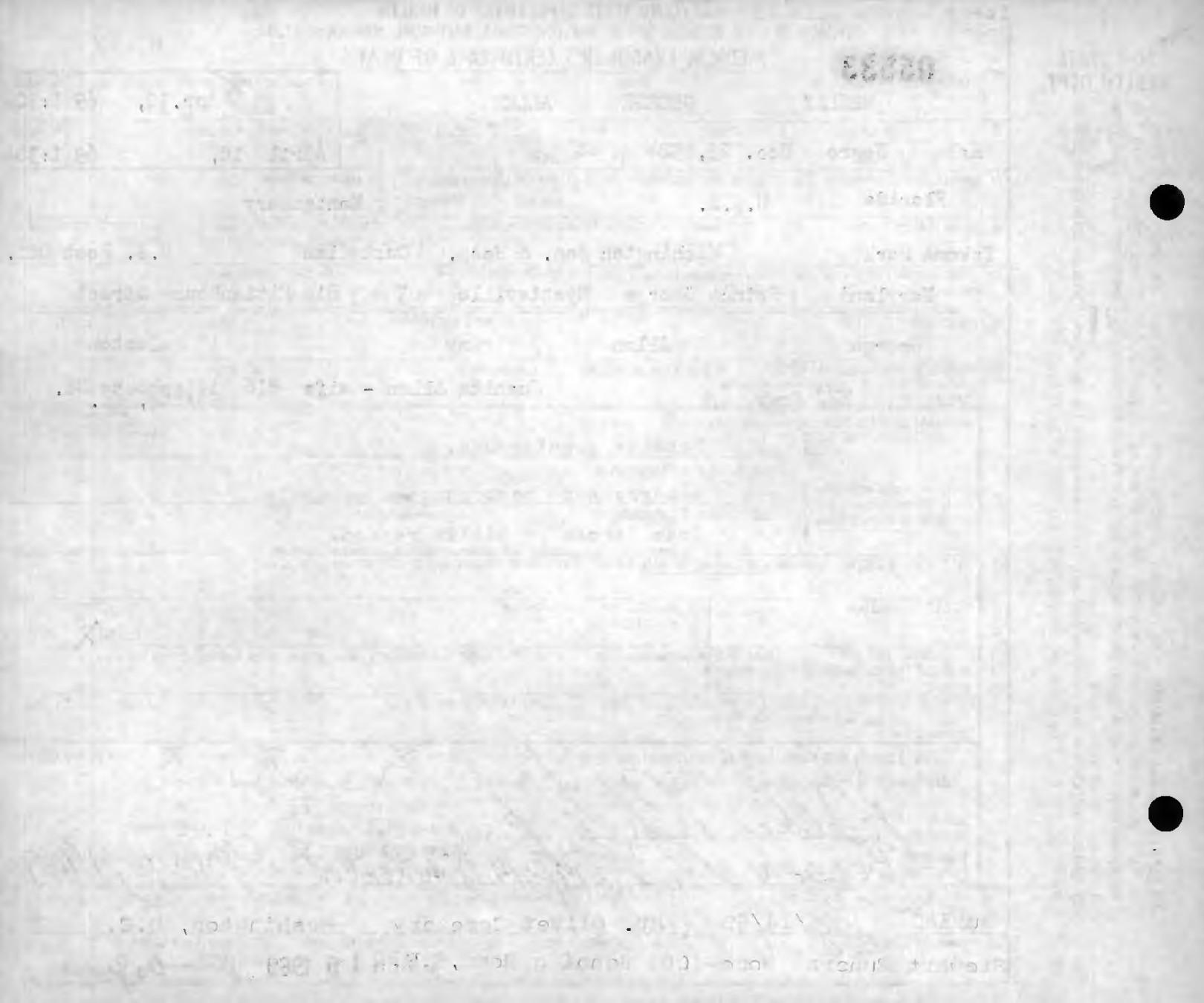
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First WESLEY	Middle GEORGE	Lost ALLEN	20. DATE KNOWN OF DEATH ESTIMATED Apr. 10, 1969	Month Apr.	Day 10	Year 69	2b. HOUR 1:30 P.M.
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH Dec. 25, 1924	6. AGE (In years less birthday) 44 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0		2d. HOUR 1:30 P.M.
7. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian		12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Off.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13c. CITY OR TOWN Prince George		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 816 Rittenhouse Street			
14. FATHER'S NAME George		Middle Allen	Last Amy	15. MOTHER'S MAIDEN NAME Puleston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. WW2 Army		17. INFORMANT Juanita Allen - wife		ADDRESS 816 Rittenhouse St., Hyattsville, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Massive spontaneous, DUE TO, OR AS A CONSEQUENCE OF (b) subarachnoid hemorrhage apparently DUE TO, OR AS A CONSEQUENCE OF (c) from Circle of Willis region.</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE Belden R. Keap</p> <p>EXAMINER'S NAME (Type) BELDEN R. KEAP M.D. Washington</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.</p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ADDRESS (Street, City, Town, or County) 4001 Benning Road, N.E., Washington, D.C.</p> <p>22b. DATE SIGNED April 10, 1969</p>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/14/69	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County) D.C.		(State)
24. FUNERAL DIRECTOR John J. Stewart Jr.		ADDRESS Stewart Funeral Home - 4001 Benning Road, N.E., Washington, D.C.	25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05534

05528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	20. DATE OF DEATH Month	Day	Year	2b. HOUR
<i>Edith</i>			<i>P</i>	<i>Allnutt</i>	<i>April</i>	<i>3</i>	<i>1969</i>	<i>10</i>	<i>M</i>
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)			IF UNDER 1 YEAR	IF UNDER 24 HRS.		
<i>Female</i>	<i>White</i>	<i>9/20/90</i>	<i>78</i>	YRS.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH			
<i>Maryland</i>	<i>USA</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>Montgomery</i>			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Bethesda</i>	<i>Suburban Hosp</i>			<i>Student</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	13e. STREET AND NUMBER			
<i>Md</i>	<i>Montg</i>	<i>Rockville</i>				<i>25 Williams St.</i>			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
<i>Alexander F</i>			<i>Prescott</i>	<i>Edith</i>	<i>Stonley</i>		<i>Kellog</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>No</i>	<i>218-34-64771</i>	<i>Stedman Prescott</i>			<i>7001 Brookville Rd Chevy Chase, Maryland 20015</i>			<i>4-5 yrs.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of uterus (endometrial)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>with regional metastases</i> stating the underlying cause (c) <i></i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				<i>19</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/1/69</i> , to <i>4/1/69</i> , that (I) (we) last saw the deceased alive on <i>4/1/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
<i>Arthur F. Woodward</i>								<i>April 3-1969</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<i>Arthur F. Woodward</i>		<i>Rockville - Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Rockville		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>			
<i>Burial</i>		<i>4/5/69</i>							
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
<i>Tyson Wheeler Funeral Home</i>		<i>1331 Rock Pike Rockville, Md.</i>			<i>APR 7 1969</i>			<i>Charles Judge</i>	

卷之三

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05529

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED			Month	Day	Year	2b. HOUR 9:30 AM		
JOHN	J.	ASERO				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	April	10	1969			
3. SEX	4. RACE	S. DATE OF BIRTH	5. AGE (in years less than 1 year) 56 yrs	6. IF UNDER 1 YEAR MONTHS	7. IF UNDER 24 HRS. DAYS	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month April Day 10 Year 1969			2d. HOUR 9:30 AM		
Male	White	9/15/1912	56 yrs			<input type="checkbox"/>	<input type="checkbox"/>	Montgomery						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				
Italy		U.S.A.								Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda			Suburban			Librarian - Defense Support Agency								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 11975 Andrew St.					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last											
Salvatore Asero			Angela Bellia											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 577-58-0270			17. INFORMANT (Wife)			ADDRESS Vera Asero-11975 Andrew St., Wheaton, Md.					
Yes <i>b/w 1942-45</i>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY.														
IMMEDIATE CAUSE (a) Coronary insufficiency with thrombosis; APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
DUE TO, OR AS A CONSEQUENCE OF														
(b) Arteriosclerotic heart disease														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
									<input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Belden R. Read M.D.</i> M.D. 22b. DATE SIGNED <i>APRIL 11, 1969</i>														
EXAMINER'S NAME (Type) <i>Belden R. Read M.D.</i> M.D. ADDRESS (Street, City, Town, or County)														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 15, 1969			23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Natl. Cemetery			23d. LOCATION (City or Town) Baltimore, Maryland (County) (State)					
24. FUNERAL DIRECTOR <i>Glen Carter Warner</i> 8434 Georgia Avenue Warner, Inc. Silver Spring, Maryland			ADDRESS			25a. REC'D BY REGISTRAR APR 17 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15ME (3)			10M REV. 1/68											

655

100-11730

100-11730

100-11730

100-11730

100-11730

100-11730

100-11730

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

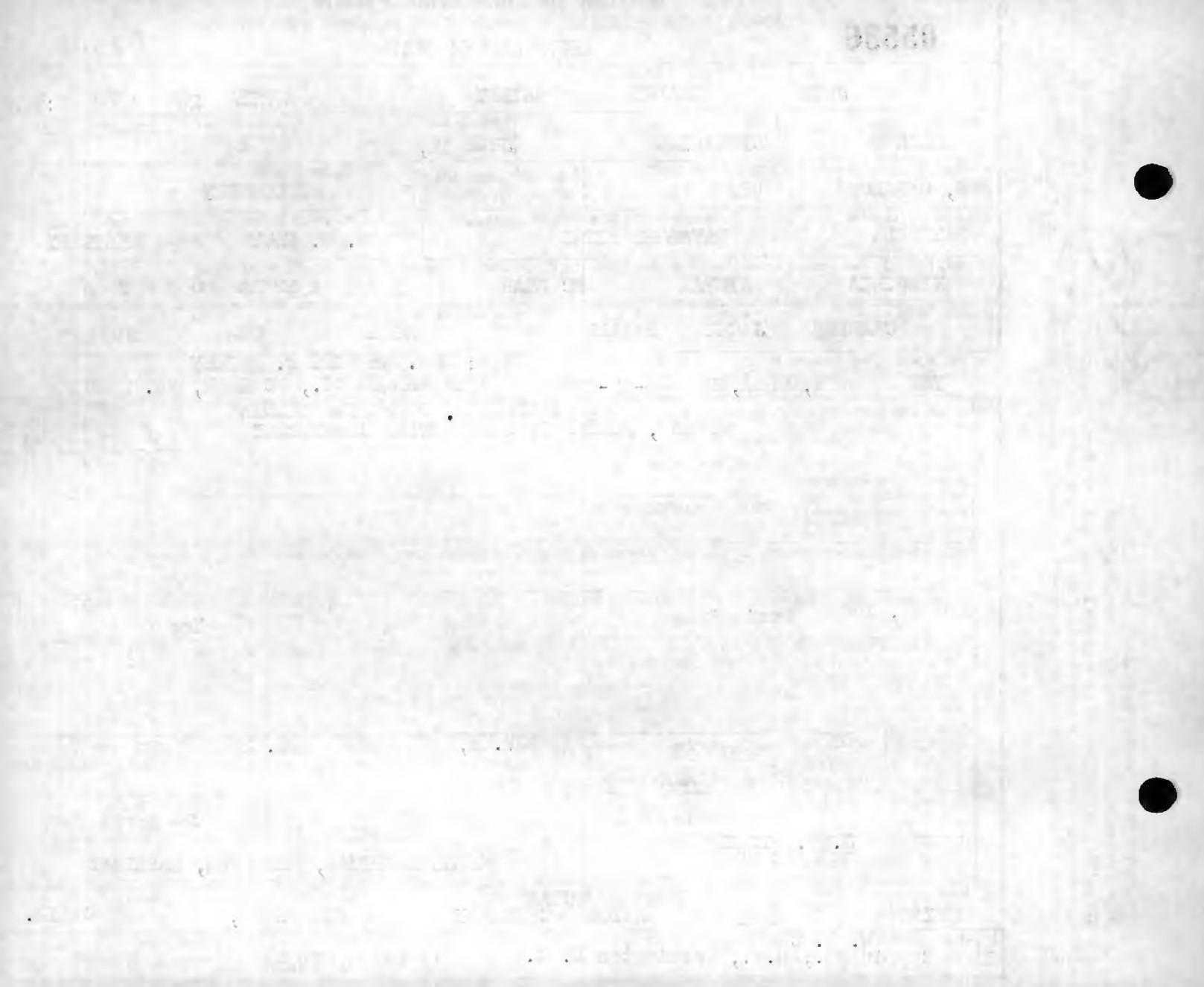
CERTIFICATE OF DEATH

05530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First JOHN	Middle BRADEN	Last BAILEY	2a. DATE OF DEATH APRIL 28	Month Year 1969	2b. HOUR 7:47 AM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JUNE 12, 1923		6. AGE (In years lost birthday) 45 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign ADA, OKLAHOMA)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) U. S. NAVY		12b. KIND OF BUSINESS OR INDUSTRY MILITARY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) VIRGINIA		13b. CITY OR TOWN FAIRFAX		13c. CITY OR TOWN MC LEAN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1322 BANQUO COURT			
14. FATHER'S NAME CHARLES		First JACKS	Middle BAILEY	Last	15. MOTHER'S MAIDEN NAME ALPHA	First ONA	Middle	Last BRADEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. YES WWII, KOREA, RVN 446-12-2269		17. DECEASED MRS. HARRIET T. BAILEY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		22d Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		MENINGIOMA, POSTERIOR CRANIAL FOSSA, STATUS POST OPERATIVE CRANIOTOMY							
		(b)									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION APR 25, 1969		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Meningioma		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from NOV. 4, 1968, to APR. 28, 1969, that <input type="checkbox"/> (we) last saw the deceased alive on APR 28 1969, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>Wissinger</i>		22c. DATE SIGNED 29 April 1969		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.				
22d. PHYSICIAN'S NAME (Type)		J. P. WISSINGER LCDR MC USNR		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5-5-69		23c. BURIAL, CREMATION FORT ROSECRANS NATIONAL CEMETERY		23d. LOCATION (City or Town) SAN DIEGO,		(County)		(State) CALIF.	
24. FUNERAL DIRECTOR W. W. CHAMBERS 1400 Chapin St., N.W., Washington D. C.		ADDRESS		25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judd</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and send to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

05537

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05531



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05534

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Notley		Howard	Barrett		Month	Day	Year	11a	11b	
3 SEX	4. RACE				5 DATE OF BIRTH			6. AGE (In years last birthday)		
Male	White				5-13-99			69	YRS.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.						Montgomery		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INST.TUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Washington San & Hosp.			Retired			Cap. Transit		
13a U.S.A. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Prince Georges		Beltsville	YES <input type="checkbox"/>	NO <input type="checkbox"/>	11704 Chilcoate Lane			
14. FATHER'S NAME First		Middle	Last	15 MOTHER'S MAIDEN NAME First			Middle	Last		
Henry Barrett				Mary C. Cook						
16a WAS DECEASED EVER IN U.S ARMED FORCES? Yes, no or unknown)		(1 yes give war or dates of service)		16b SOCIAL SECURITY NO.	17. INFORMANT		Address			
no					Mary EXX I. Miller (Dau.)		Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) 401c		minutes								
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRAGE		4 days								
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE + old CVA.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No.		City or Town		County	State
22o. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 4-18, 1969, to 4-22, 1969, that <input type="checkbox"/> (we) last saw the deceased alive on 4-22, 1969, and that in <input type="checkbox"/> (my) (<u>our</u>) opinion death occurred on the date and hour and fram the causes stated above. <input type="checkbox"/> (we) (did) <input type="checkbox"/> (a not) view the body after death.										
22b. SIGNATURE John L. Ford MD		DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4-23-69		
22d. PHYSICIAN'S NAME (Type)		JOHN LOUIS FORD			22e. ADDRESS 831 UNIVERSITY BLVD E. SILVER SPRING, MD. 2080					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/26/69		23c. NAME OF CEMETERY OR CREMATORIAL Gate Of Heaven			23d. LOCATION (City or Town) Wheaton, Maryland		(County)	(State)
Burial										
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS Wash., DC Simmons Bros. 1661- Good Hope Rd. SE			25a. REC'D BY REGISTRAR APR 25 1969			25b. REGISTRAR'S SIGNATURE Charles, Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the state Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05539 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05533

1. DECEASED-NAME (Type or Print)		First William	Middle H. oward	Lost Barringer	2a. DATE KNOWN OF ESTI- MATED	Month 4	Day 69	Year 69	2b. HOUR 12:30 P
3 SEX	4. RACE	S. DATE OF BIRTH	6 AGE (In years (birthday) 65 YRS.)	7 IF UNDER 1 YEAR MONTHS DAYS	8 F UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 4	Day 3	Year 1969	2d. HOUR 12:30 P
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San & Hosp			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - 1st Army			12b KIND OF BUSINESS OR INDUSTRY Friend	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13c CITY OR TOWN Takoma Park		13d INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 8502 Garland Ave. T.P., Md.			
14. FATHER'S NAME First William		Middle Barringer	Last	15. MOTHER'S MAIDEN NAME First Anna		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW II		17 INFORMANT Takoma Park, Md. ADDRESS 2 Garland Ave. Mrs. Marie L. Barringer Beldin Barkox		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) metastasis DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Geap</i>		EXAMINER'S NAME (Type) BELDEN R. GEAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Towson, APRIL 3, 1969		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 7, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Burtonsville Union Cemetery		23d. LOCATION (City or Town) Burtonsville, Md.		(County) (State)	
24. FUNERAL DIRECTOR Warner C. Humphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE APR 11 1969		25b. REGISTRAR'S SIGNATURE <i>Registrator</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First LAURA	Middle NAOMI	Last BEALL	2a. DATE OF DEATH Month APRIL	Day 23	Year 1969	2b. HOUR 10⁰⁰ AM		
3. SEX FEMALE		4 RACE WHITE	5. DATE OF BIRTH February 17, 1880			6. AGE (In years last birthday) 89		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery, Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5720 Huntington Parkway			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 342 East Third Street			
14. FATHER'S NAME First Curtis		Middle Michael	Lost	15. MOTHER'S MAIDEN NAME First Mary		Middle Williams	Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 214-10-5834D		17. INFORMANT Mrs. William E. Ross		Address Bethesda, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1542											
(b) ANNULEAR CARCINOMA OF RECTUM											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 12/27 , 19 66 , to present , 19 69 , that (I) (we) last saw the deceased alive on 3/25/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Irving Lowell Marks M.D.</i>		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4/23/69			
22d. PHYSICIAN'S NAME (Type)		Dr. Irving Lowell Marks M.D.		22e. ADDRESS 320 University Blvd. East Sil. Sp. Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-1969		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		23d. LOCATION (City or Town) Frederick, Frederick, Md.		(County)		(State)	
24. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i>		ADDRESS Frederick, Maryland		25a. REGD BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE <i>Chanta, India</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05541

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First Mary	Middle V.	Last Beard	2a. DATE KNOWN OF EST. DEATH MATED	Month April	Day 4	Year 1969	2b. HOUR 2:30 P.M.	
3. SEX F	4. RACE Negro	S. DATE OF BIRTH 10/9/00	6. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13c. CITY OR TOWN 13d. COUNTY		13e. STREET AND NUMBER 744 Girard St., N.W.					
14. FATHER'S NAME Charles		Middle Taper	Last	15. MOTHER'S MAIDEN NAME Lillie		First Middle Last Finhey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Son - Lucien Bannister		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> CONDITONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (b) <u>Cardio Vascular Disease -</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> YEARS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Fracture of left hip.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH:		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>4/21/1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) <u>Fall at home while employed.</u>					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No <u>3715 Cherry Chase Dr.</u>		City or Town <u>Bethesda</u>	County <u>Montgomery</u>	State <u>Md.</u>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<u>John E Bell</u>			CHIEF MEDICAL EXAMINER M.D.		22b. DATE SIGNED <u>April 4, 1969</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Apr 4, 8-69</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Oasis Cemetery</u>		23d. LOCATION (City or Town) <u>Wheaton</u>		(County) <u>Prince George's Co.</u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Contingent Funeral Home</u>		24b. ADDRESS <u>1 JSCORP ST</u>		24c. REC'D. BY REGISTRAR <u>APR 8 1969</u>		24d. DATE <u>APR 8 1969</u>		24e. VITAL STATISTICS <u>Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05536

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours after death, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05542		MAY 20 1969										05536	
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		Month	Day	Year	2b. HOUR			
James		F.	Beavers		Apr	20		1969	6 PM	40	M		
3. SEX		4 RACE		5 DATE OF BIRTH	6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 IF UNDER 24 HRS HOURS	10b. MONTH			
Male		White		10/16/96	72 yrs.					Md			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH							
Washington D.C.		U.S.A.				Montgomery							
10. CITY, OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospt			Short metal Workers Retired								
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland		Mont.		Chevy Chase		YES		2912 Terrace Drive					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last				
Maurice				Beavers	Sarah								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		577-03-0943A		Faye J Schaeffer		301 Scott Dr		10 days					
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cerebral arterosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pulmonary emphysema</u>													
19c. MEDICAL CERTIFICATION		19d. DATE OF OPERATION		19e. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 4-9 1967, to 4-20 1967, that (I) (we) last saw the deceased alive on 4-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>M. J. Shapin</u>		22c. DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22d. DATE SIGNED 4-20-69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		Holy Cross Hospt									
M. J. Shapin													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-23-69		23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEM.		23d. LOCATION (City or Town) COLMAR MANOR MD.		(County)		(State)			
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.		ADDRESS 1400 Chapin St. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE Charles George							

51



1 No HOSPITAL .. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05543

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05537

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)	First <i>Henry</i>	Middle <i>A</i>	Last <i>Belding</i>	2a. DATE OF DEATH Month <i>4</i>	Day <i>22</i>	Year <i>1969</i>	2b. HOUR <i>4 P.M.</i>
3 SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>3-18-86</i>	6 AGE (In years last birthday) <i>83</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>
7a BIRTHPLACE (State or foreign country) <i>Michigan</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baburba</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>R.P.T. ENGINEER PLUMBING</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>PLUMBING</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>D.C.</i>	13b. COUNTY <i>—</i>	13c. CITY OR TOWN <i>Washington</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>4842 Davenport St N.W.</i>			
14 FATHER'S NAME First <i>HENRY</i>	Middle <i>—</i>	Last <i>BELDING</i>	15 MOTHER'S MAIDEN NAME First Middle Last <i>N/A</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>No</i>	16b SOCIAL SECURITY NO. (If yes give war or dates of service) <i>577-03-0907</i>	17. INFORMANT <i>Wife Mrs Nellie F Belding</i>	Address <i>Same as above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Cardiac failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Generalized arteriosclerosis</i> <i>10 years</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary embolism</i>							
19a. DATE OF OPERATION <i>—</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>	20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>				
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>—</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC <i>—</i>	21f LOCATION Street or R.F.D. No. <i>—</i>	City or Town <i>—</i>	County <i>—</i>	State <i>—</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>August 1, 1957</i> to <i>April 21, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 21, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>C. Roger Kurtz, M.D.</i>	ATTENDING PHYS. <i>—</i>	MED. DIRECTOR <input checked="" type="checkbox"/> <i>—</i>	STAFF PHYS <input type="checkbox"/> <i>—</i>	22c. DATE SIGNED <i>4-22-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>C. Roger Kurtz, M.D.</i>	22e. ADDRESS <i>3701 Connecticut Ave. NW Washington, D.C.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>4/25/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>	23d. LOCAT OH (City or Town) <i>WASHINGTON, D.C.</i>	(County) <i>—</i>	(State) <i>—</i>		
24. FUNERAL DIRECTOR <i>Jos. GAWLER'S Sons, 5130 WISCONSIN AVE., WASHINGTON, D.C.</i>	ADDRESS <i>—</i>	25a. REC'D BY REGISTRAR DATE <i>APR 25 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Alvarez Judge</i>				

6
1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05544

05538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 did should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First FLORENCE	Middle M.	Last BELL	2a. DATE OF DEATH Month April Year 1959	2b. HOUR 4 P.M.
3. SEX Female		4. RACE White		S. DATE OF BIRTH January 5, 1902	6 AGE (in years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? US		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 215 Beall Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) KIXXER KIXXARY Retired		12b. KIND OF BUSINESS OR INDUSTRY US Govt.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 215 Beall Ave.
14. FATHER'S NAME First Harry		Middle Hooper	Last	15. MOTHER'S MAIDEN NAME First Clara		Middle Barse
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown No		16b. SOCIAL SECURITY NO. 577-22-2184		17 INFORMANT Charles N. Bell-same item # 13A		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF Ischaemic Cardioma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) DUE TO, OR AS A CONSEQUENCE OF lost.		(c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 7-28, 1968 , to 4-3, 1969 , that (I) (we) last saw the deceased alive on 7-9-67 at 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>D L Bucci / RC Mahan</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-8-69		
22d. PHYSICIAN'S NAME (Type) D L. Bucci / RC Mahan		22e. ADDRESS 834 Veirs Mill Rd Rockville, Md				
23a. BLR A. CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4/8/69		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Prince George, Maryland
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock Pike Rockville, Maryland		25a. REC'D BY REGISTRAR APR 9 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

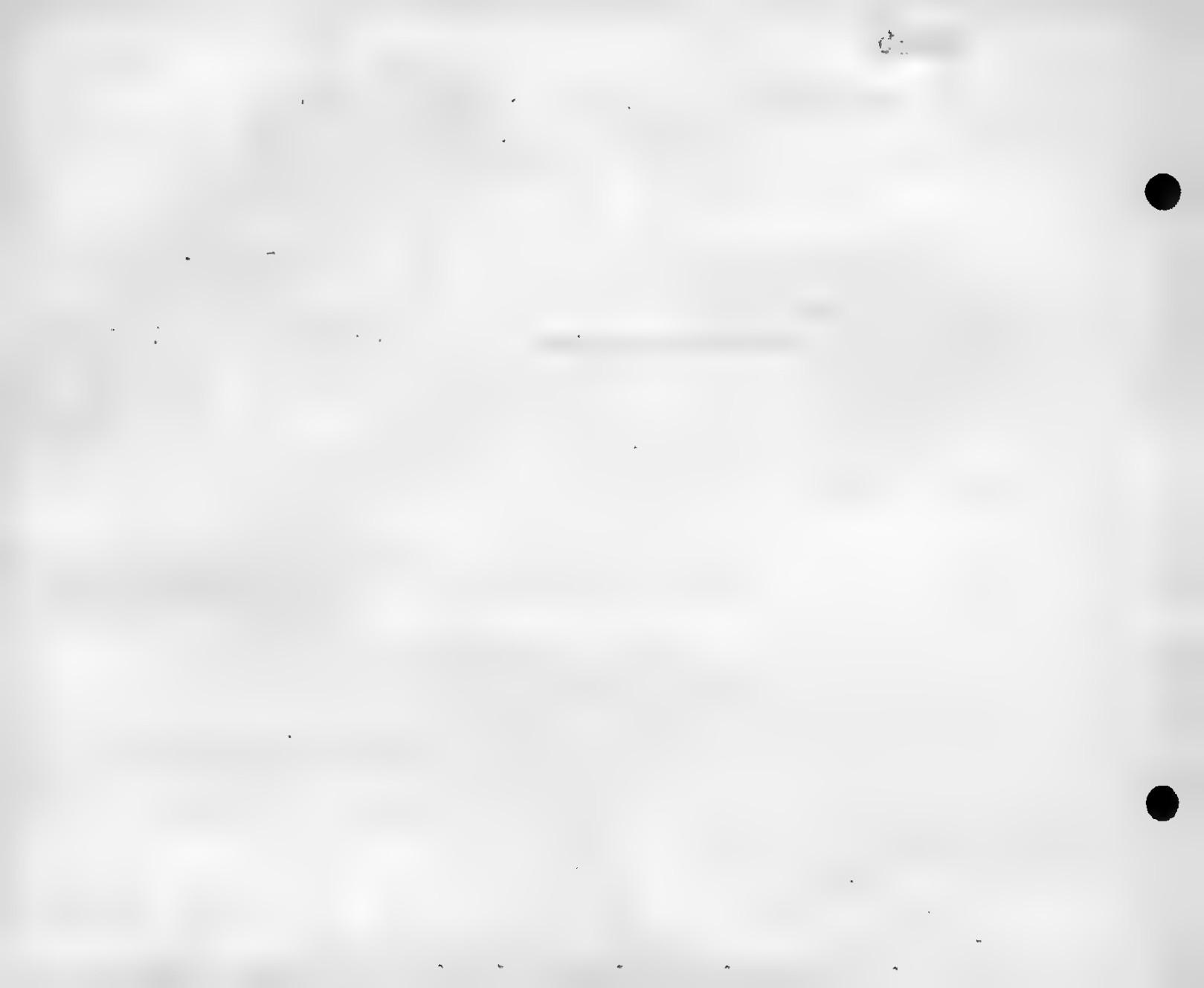
CERTIFICATE OF DEATH

05545

05539

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <u>Leon</u>	Middle <u>Benefiel</u>	Last <u>Guisinger</u>	2d DATE OF DEATH Month <u>APRIL</u>	Doy <u>10</u>	Year <u>1969</u>	26 HOUR <u>10 AM</u>							
3. SEX <u>MALE</u>		4 RACE <u>White</u>	5 DATE OF BIRTH <u>Feb. 22, 1892</u>		6 AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR MONTHS <u>7</u>		F UNDER 24 HRS HOURS <u>10</u>		MIN <u>00</u>				
7a BIRTHPLACE (State or foreign country) <u>Indiana</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A - America</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>							
10 CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASHINGTON San + Hosp.</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired Supervisor</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>									
13a. USUAL RESIDENCE (Where deceased lived at institution or residence before admission) STATE <u>Maryland</u>		13c CITY OR TOWN <u>PRINCE GEORGE'S AUREL</u>		14. INSD. CITY LIM TSP? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>16031 Gerald Rd.</u>									
14. FATHER'S NAME First <u>Joel</u>		Middle <u>Leon</u>	Last <u>Benefiel</u>	15. MOTHER'S MAIDEN NAME First <u>Jeannette</u>		Middle <u></u>	Last <u>Guisinger</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>YES</u>		16b. SOCIAL SECURITY NO <u>WT</u>		7. INFORMANT <u>HOSPITAL RECORDS</u>		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4/17</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Congestive heart failure</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute hypoglycemia</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>atrioventricular fibrillation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis 1964 & 1966.</u>															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. <u>19</u> Month <u>April</u> Day <u>10</u> Year <u>1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>fall</u>											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <u></u>		City or Town <u></u>		County <u></u>		State <u></u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 10</u> , 1969, to <u>April 10</u> , 1969, that (I) (we) last saw the deceased alive on <u>April 10</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Sydney Leverith, M.D.</u>		ATTENDING DEGREE PHYS		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		<input type="checkbox"/> DATE SIGNED <u>April 10, 1969</u>							
22d. PHYSICIAN'S NAME (Type) <u>Sydney Leverith, M.D.</u>		22e. ADDRESS <u>9250 Calverville Rd., Silver Spring, MD</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/14/1969</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u>		(County) <u></u>		(State) <u></u>					
24. JEWELRY CLOTHING ACCESSORIES <u>None</u>		ADDRESS <u>Maryland</u>		25a. REC'D. BY REGISTRAR <u>APR 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									
VR A15 45M - 1															



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

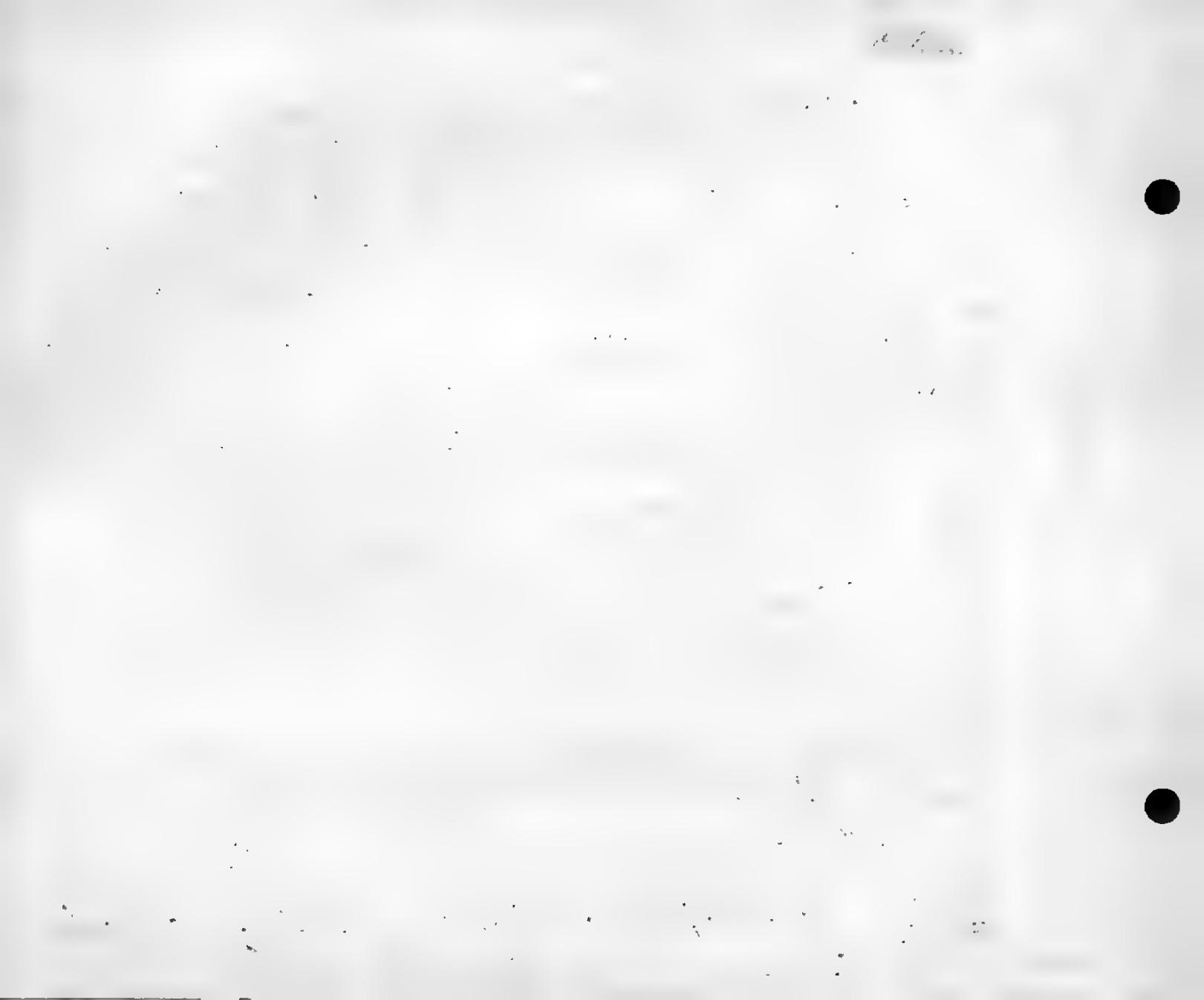
05540

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 through 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR M
WILLIAM ANTHONY BENJAMIN						April 7 1969	
3. SEX MALE		4 RACE WHITE	5 DATE OF BIRTH MAY 8, 1884		6 AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED		9. COUNTY OF DEATH MONTGOMERY		Md.
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COLONIAL VILLA		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) INSURANCE		12b. KIND OF BUSINESS OR INDUSTRY SAVAGE	
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. LIVED, IF INSTITUTION. RESIDENCE BEFORE COUNTY MONTGOMERY		13c. CITY OR TOWN MD.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 3452 CHISWICK COURT	
14. FATHER'S NAME THOMAS		First	Middle	Lost	15. MOTHER'S MAIDEN NAME WILHELMINA	Middle	Last DECKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17 INFORMANT MRS. MARJORIE I. DREW		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		485 X		DUE TO, OR AS A CONSEQUENCE OF <i>acute bronchopneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 d	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Ben. A.S.E CVA, CHF</i>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-12, 1968</u> , to <u>4-1, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-28 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur Walter</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4-2-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1106 SPRINGS ST. SS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE APR 4 1969	23c. NAME OF CEMETERY OR CREMATORIUM Tyrone Farm		23d. LOCATION (City or Town) Bel Air - Bel Air Md.		(County) (State)
24. FUNERAL DIRECTOR Arthur Walter		ADDRESS 254 Second St. - 06	25e. REC'D BY REGISTRAR DATE APR 7 1969		25d. REC'D BY JUDGE George J. Judge		



Item #1 File #G414 7/1/69 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05547

CERTIFICATE OF DEATH

05541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Peter	Middle	Last	2a. DATE OF DEATH Month	April	Year	1969	2b. HOUR 8 PM	
3. SEX M.	4. RACE White	5. DATE OF BIRTH April 19-69		6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED		NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery		MIN	17 42	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
13b. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13c. CITY OR TOWN Montgomery	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4612 Flower Valley Lane						
14. FATHER'S NAME John Fiedling	First	Middle	Last	15. MOTHER'S MAIDEN NAME Sharon Ruth	First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT Father		Address 4612 Flower Valley Lane		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16½ hours			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intracutertine compression of umbilical cord</u></p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1969</u>, to <u>April 19, 1969</u>, that (I) (we) last saw the deceased alive on <u>April 19, 1969</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.</p>									
<p>22b. SIGNATURE <u>James A. Davis Jr</u></p>									
22c. ADDRESS JAMES A. DAVIS JR 8218 WISCONSIN AVE. BETHESDA		22c. DATE SIGNED April 19, 1969							
23a. BURIAL, CREMATION, BURIAL		23b. DATE 4/23/69	23c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery	23d. LOCATION (City or Town) Rockville, Maryland		(County)			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock Pike Rockville, Maryland		25a. REC'D BY REGISTRAR APR 24 1969	25b. REGISTRAR'S SIGNATURE Charles J. Gandy				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05548

05542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First BERTHA	Middle NMN	Last BERNHARD	2a. DATE OF DEATH Month 4 Day 26 Year 69	2b. HOUR 7 45 AM
3. SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 9-4-36	5. AGE (In years last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) IOWA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY	Md.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer	12b. KIND OF BUSINESS OR INDUSTRY U.S. DEP'T. OF FRIENDS HOUSE		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SANDY SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER FRIENDS HOUSE	
14. FATHER'S NAME First LEWIS	Middle --	Lost VIOLET	15. MOTHER'S MAIDEN NAME First LYOIA	Middle --	Lost JENKS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown	16b. SOCIAL SECURITY NO 220-34-8515	17. INFORMANT 	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA - TERMINAL DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE - POUTINE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS - GENERALIZED APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK 3 WKS YRS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No.	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1964-19- to 4/26/69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/26/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Donald R. Lewis MD	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4/30/69
22d. PHYSICIAN'S NAME (Type) DONALD R. LEWIS	22e. ADDRESS BURTONSVILLE MD				
23a. <input type="checkbox"/> CREMATION, <input checked="" type="checkbox"/> REBURN (Specify)	23b. DATE APRIL 26 1969	23c. NAME OF CEMETERY OR CREMATORIAL LIFE FUNERAL HOME	23d. LOCATION (City or Town) WASIT. D.C.	(County)	(State)
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Taylorsville Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05549

05543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) SAMUEL XKXNLSX				Middle	Lost	BERKMAN	2a. DATE KNOWN OF EST - DEATH MATED	Month	Day	Year	2b. HOUR					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS	4	11	19	69	5:45 P.M.						
male	cauc	July 1890	78 yrs	MONTHS	DAVS -	MIN	2c. DATE PRONONCED DEAD	Month	Day	Year	2d. HOUR					
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH													
RUSSIA	U. S. A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTGOMERY													
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) 916 Clintwood Dr. S.S.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring																
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER												
MD	MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	916 CLINTWOOD DRIVE												
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost									
MAYER			BERKMAN	UNASCERTAINABLE												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS													
NO	225-05-3462	ALBERT BERKMAN (son)	916 CLINTWOOD DR. SILVER SPRING, MD BETWEEN ONSET AND DEATH													
18. CAUSE OF DEATH (Enter only one cause per line) (or (o), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)								Acute Coronary Insufficiency								
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b)								Arteriosclerotic Heart Disease								
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE Belden R. Reap																
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.																
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL												23b. DATE Apr. 13, 1969	23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden	23d. LOCAT ON (City or Town) Falls Church, Virginia	(County)	(State)
24. FUNERAL DIRECTOR Donald M. Stein												ADDRESS 232 Carroll	25a. PR BY REGISTRAR PR 1-5 1969	25b. PERS. NATL Hebrew Memorial Funeral Home St., N.W. Wash., D.C.		



2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05550

05544

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)				First <i>JOSEPH</i>	Middle <i></i>	Last <i>BERNARD</i>	20. DATE OF DEATH Month <i>APRIL</i>	Day <i>26</i>	Year <i>1969</i>	2b. HOUR <i>10:25 P.M.</i>		
3 SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>9/12/02</i>			6. AGE (in years last birthday) <i>66 yrs.</i>		IF UNDER 1 YEAR MONTHS <i></i>		IF UNDER 24 HRS HOURS <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i>						
10 CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>SURGEON GEN'L HOSP</i>			12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>COMMERCE Dept. of 215. GOV't.</i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DISTRICT OF COLUMBIA</i>		13b. CITY OR TOWN <i>WASHINGTON</i>		13d. INSIDE CTY. LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3470 36TH ST</i>						
14. FATHER'S NAME First <i>HARRY</i>		Middle <i></i>	Last <i>BERNARD</i>	15. MOTHER'S MAIDEN NAME First <i>ROSA</i>		Middle <i>AMBRENNY</i>	Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO <i></i>		16c. INFORMANT <i>JAMES. BERNARD</i>		Address <i>Bridgeton N.J.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION RECENT & REMOTE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIOSCLEROSIS WITH THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Apr., 1969</u> , to <u>26 Apr., 1969</u> , that (I) (we) last saw the deceased alive on <u>26 Apr., 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert T Kelley</i>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>26 Apr 69</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT T KELLEY</i>		22e. ADDRESS <i>1302-181ST. NW. D.C.</i>										
23a. BURIAL CREMATION, REMOVAL (Specify) <i></i>		23b. DATE <i>4/30/69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Park Cem.</i>		23d. LOCATION (City or Town) (County) <i>PARADISE N.J.</i>		(State)				
24. FUNERAL DIRECTOR <i>BERNARD DANZANSKY</i>		ADDRESS <i>3501-14th Street WASH. D.C.</i>		25a. REC'D BY REGISTRAR <i>MAY 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles DeLoach</i>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

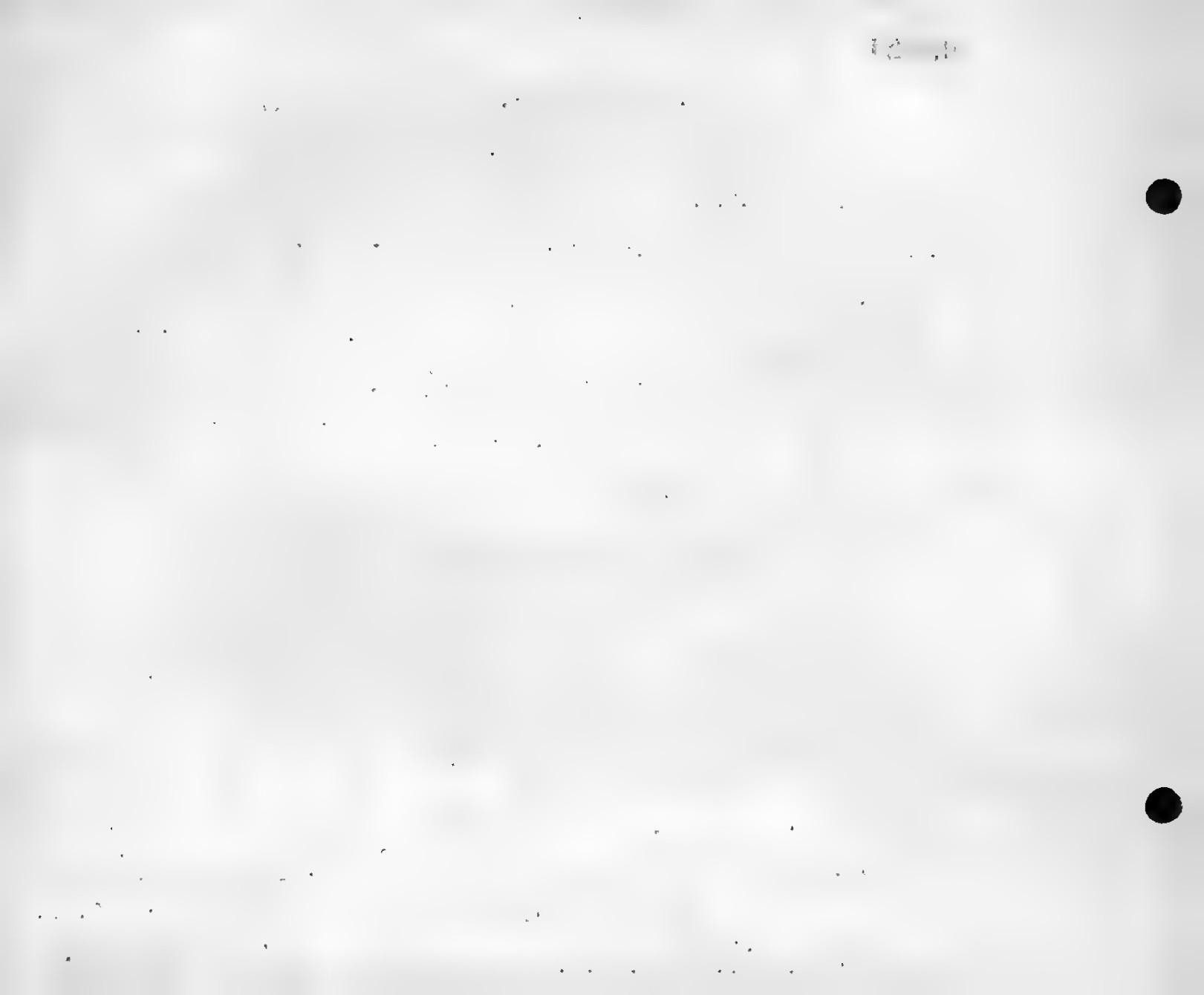
05551

05545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First Stanley	Middle Leon	Last Betesh	2a. DATE OF DEATH Month April	Day 1	Year 1969	2b. HOUR 7:50 M
3. SEX		4 RACE Male		S. DATE OF BIRTH 10 July 1943	6. AGE (in years last birthday) 25		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Store Owner		12b. KIND OF BUSINESS OR INDUSTRY Self-employed		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1111 University Blvd., West		
14. FATHER'S NAME First Leon		Middle Betesh	Last	15. MOTHER'S MAIDEN NAME Alice	Middle	Last Betesh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-56-1254		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Progressive Pulmonary Infiltration with/</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hodgkin's Disease</u> 1 year <u>XOU/X</u> <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> (b) <u>Hodgkin's Disease</u> 5 years <u>DUE TO, OR AS A CONSEQUENCE OF</u> <u>DUE TO, OR AS A CONSEQUENCE OF</u> (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>12 February, 1969</u> , to <u>1 April, 1969</u> , that <u>XOU</u> (we) last saw the deceased alive on <u>1 April, 1969</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I) (we) (did) (did not) view the body after death.</u>								
22b. SIGNATURE <u>Clarence H. Brown, M.D.</u>		DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 1 April 1969		
22d. PHYSICIAN'S NAME (Type) Dr. Clarence H. Brown		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/1/69		23c. NAME OF CEMETERY OR CREMATORIAL OhevSholom Talmud Torah		23d. LOCATION (City or Town) Washington, D. C.	(County) (State)	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons 3501 14th St., NW., Wash., D.C.				25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M : 1/69

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2d. DATE OF DEATH Month Day Year	2b. HOUR 3 ¹⁵ A.M.	
<i>Joseph</i>		<i>J.</i>	<i>BEHRELEY</i>		<i>April 28 1969</i>		
3. SEX <i>m.</i>	4 RACE <i>w</i>	5. DATE OF BIRTH <i>6/19/61</i>		6. AGE (in years last birthday) <i>67</i>	7. UNDER 24 HRS. MONTHS DAYS HOURS MIN		
7. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital g.v. street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. L.S.JAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE <i>Maryland</i>		13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>5009 Rockwood Lane</i>			
14. FATHER'S NAME First <i>JOHN</i>	Middle <i>Joseph</i>	Lost	15. MOTHER'S MAIDEN NAME First <i>CATHERINE</i>	Middle <i>LUCILLE</i>	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i>		16b. SOCIAL SECURITY NO (If yes give war or dates of serv etc)	17. INFORMANT <i>Evelyn BETTELEY - WIFE</i>	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ORGANIC BEHN SYNDROME w PSYCHOSIS</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4311</i>		DUE TO, OR AS A CONSEQUENCE OF <i>(b) CEREBRAL SCLEROSIS</i>					
		DUE TO, OR AS A CONSEQUENCE OF <i>(c)</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>FEB. 27, 1968</i> , to <i>APRIL 28, 1969</i> , that (I) (we) last saw the deceased alive on <i>APRIL 27, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert G. Angle M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>APRIL 28, 1969</i>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Apr. 30, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Hill Cemetery</i>	23d. LOCATION (City or Town) <i>Washington, D.C.</i>		(County)	(State)	
24. FUNERAL DIRECTOR DeVol Funeral Home	ADDRESS <i>2222 Wis. Ave. Wash. D.C.</i>	25a. REG'D BY REGISTRAR <i>MAY 3 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Frank J. DeVol</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05553

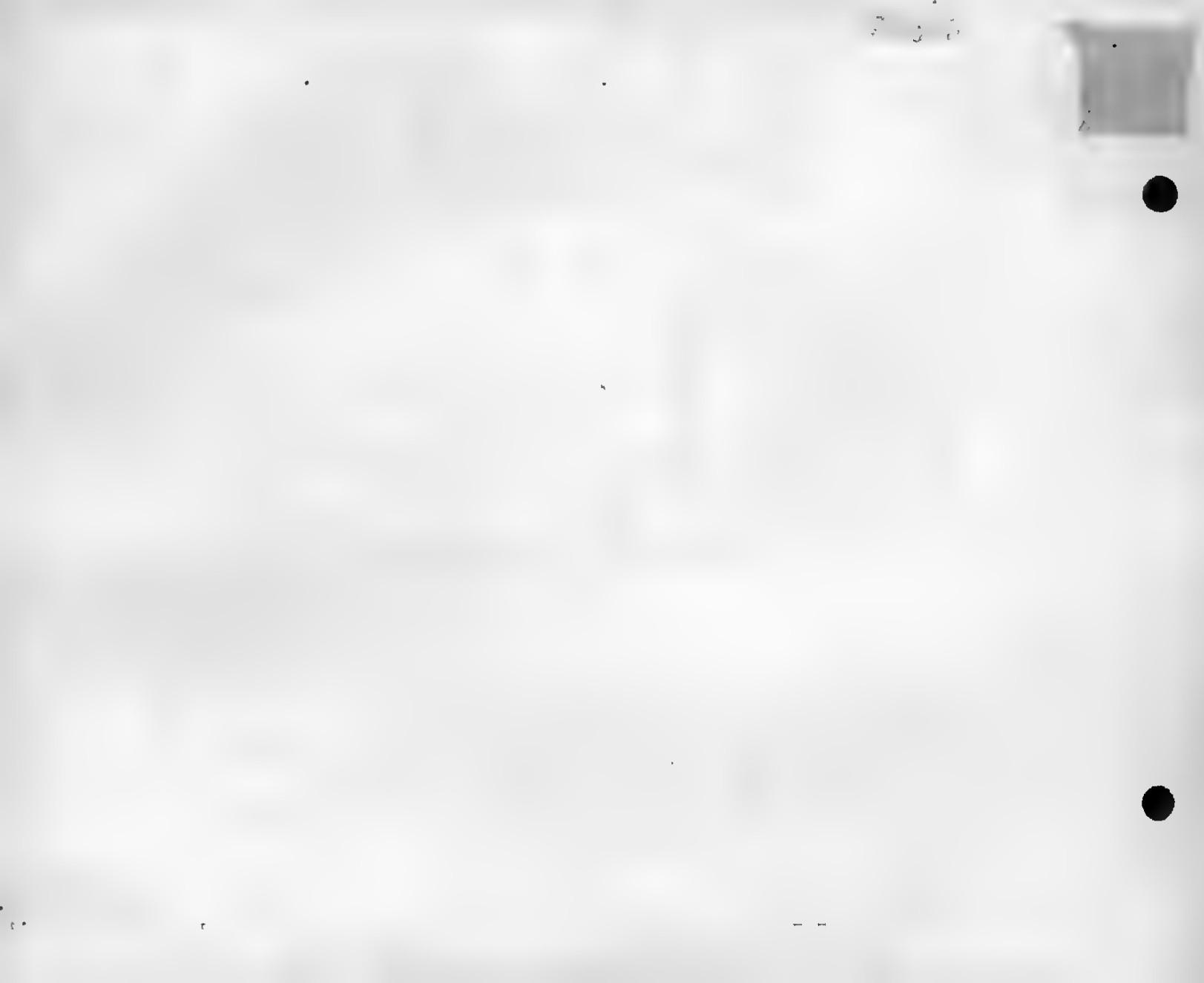
05547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First <u>Frank</u>	Middle <u>A.</u>	Last <u>Biberstein Jr.</u>	2a. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1969</u>	2b. HOUR 2 30 P.M.
3. SEX <u>Male</u>	4. RACE <u>White</u>	S. DATE OF BIRTH <u>6-7-00</u>	6. AGE (In years at birthday) <u>68</u>	7. IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	8. IF UNDER 24 HRS HOURS <u>0</u> MIN. <u>0</u>
7a. BIRTHPLACE (State or foreign country) <u>Penns</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Montgomery</u>	9. COUNTY OF DEATH <u>Montgomery</u>	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Bethesda Hospital</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Physician</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Catholic Univ</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before dismissal) STATE <u>Maryland</u>	13c. CITY OR TOWN <u>Montgomery Kensington</u>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>102-25 Kensington Hwy</u>		
14. FATHER'S NAME First <u>Frank</u> Middle <u>A.</u> Last <u>Biberstein Sr.</u>	15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u></u> Last <u>Malone</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO. <u>578-05-4242</u>	17. INFORMANT <u>Shirley T. Biberstein - wife - addressee</u>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF lost. (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <u></u>	City or Town <u></u>	County <u></u>	State <u></u>
22a. I certify that (I) (this hospital) attended the deceased from about <u>June 1968</u> to <u>4/30 1969</u> , that (I) (we) last saw the deceased alive on <u>9/13/68</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>RICHARD H. POLLIN MD</u>	22c. DEGREE <u>MD</u>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <u>4/30/69</u>
22d. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLIN MD</u>	22e. ADDRESS <u>1040A CONNECTICUT AV KENSINGTON MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-2-1969</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) <u>Silver Spring, Montgomery Co., Md.</u>	(County) <u></u>	(State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SON. INC.</u>	25a. ADDRESS <u>8190 WISCONSIN AVE., N. W. WASH.. D. C. 20016</u>	25b. REGISTRATION NUMBER <u>MAY 6 1969</u>	25c. REGISTRAR'S SIGNATURE <u>REG. NO. 1142</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05554

CERTIFICATE OF DEATH

05548

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	2b. HOUR P.M.
		Frances	Margaret	Bonta	April	2	4:00
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		White		22 October 1910		58	YRS
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Tennessee		U.S.A.				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		
Bethesda		The Clinical Center, NIH			Credit clerk		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
Virginia		Arlington		Arlington		716 N. Tazewell Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		16. Last
		Julias	Moody		Cora May		Alice Bauer
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
no		085-03-8044		The Medical Record Address The Clinical Center, NIH, Bethesda Md. 20201		few hours	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Septicemia					
17 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF Peritonitis and Diverticulitis (b) with perforation of sigmoid colon					
		DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma of the breast					
18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours							
few hours-days							
9 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 9 February, 1969, to 2 April, 1969, that (I) (we) last saw the deceased alive on 2 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Itamar B. Abrass, M.D.		22c. DATE SIGNED 2 April 1969					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda Md. 20201					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE April 4, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Arlington Funeral Home 3901 N. Fairfax Dr. Arlington, Va.		25a. REC'D BY REGISTRAR APR 9 1969					
		25b. REGISTRAR'S SIGNATURE Charles George					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05549

05555

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours of death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR AM PM
<i>Mr Andrew</i>				<i>Booke</i>	4 23 1969	8:30 AM
3. SEX		4 RACE		5. DATE OF BIRTH	1882	6 AGE (in years last birthday)
<i>Male</i>		<i>white</i>		<i>Jan 19, 1882</i>	87	7 MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH		
<i>Sweden</i>		<i>USA</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Montgomery</i>		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life)	
<i>Wheaton Md</i>		<i>Wheaton Nursing Home</i>			<i>Conductor</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
<i>Md</i>		<i>Montgomery</i>	<i>Silver Spring</i>	<i>YES</i>	<i>8215 Schrider St. S.S.</i>	
14. FATHER'S NAME		15. MOTHER'S MARRIED NAME	16. SOCIAL SECURITY NO.			
<i>Alex Niles Anderson Booke</i>		<i>Marguerite Pearson</i>	<i>529-05-2867</i>			
16a. WAS DECEASED EVER IN J.S. ARMED FORCES? Yes, no, or unknown?		16b. SOCIAL SECURITY NO.	17. INFORMANT			
<i>Yes</i>		<i>529-05-2867</i>	<i>Alta S. Booke 8215 Schrider St. (wife) 1st s. Silver Spring</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
		<i>Intrabib myocardial infarct hours</i>				<i>hours</i>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (c)				
		<i>Sec. arterioclures</i>				<i>years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>(Acromegaly) the prostate</i>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (1) (this hospital) attended the deceased from <i>3/28</i> , 1967, to <i>4-23</i> , 1969, that (1) (we) last saw the deceased alive on <i>4-23</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>John W. Miller MD</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4-23-69</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<i>John W. Miller MD</i>		<i>1106 Springs St. SS 1962</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, or Town)	(County)	(State)	
<i>Burial</i>	<i>Apr. 26, 1969</i>	<i>Nat'l. Mem. Pk. Cemetery</i>	<i>Falls Church, Virginia</i>			
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
<i>P. J. Smith</i>	<i>8434 Georgia Avenue Warren E. Humphrey, Inc. Silver Spring, Md.</i>	<i>APR 29 1969</i>	<i>McLennan, Virginia</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05556

CERTIFICATE OF DEATH

05550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Harry	Middle (None)	Lost	2a. DATE OF DEATH Month April	Year 1969	2b. HOUR A 2:22M
3. SEX Male	4 RACE White	5. DATE OF BIRTH March 26, 1893		6. AGE (In years last birthday) 76 yrs.	F UNDER MONTHS 3	YEAR DAYS 3	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Russia	7b. CITIZEN OF WHAT COUNTRY? America	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret'd.) MERCHANT - GASOLINE STATION		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) District of Col.	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INS'D CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 707 Hemlock St., NW			
14. FATHER'S NAME BERYL	First Borow	Middle	Lost	15. MOTHER'S MAIDEN NAME First HANNAH	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 579-01-5942	17. INFORMANT Pt's Chart		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4100		<i>Coronary occlusion, myocardial infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arterio Sclerotic Cardiovascular Disease		<i>Arterio Sclerotic Cardiovascular Disease</i>		17 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSIVE CARDIOVASCULAR DISEASE							
19a. MEDICAL CERTIFICATION	19c. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1969 , to April 10, 1969 , that (I) (we) last saw the deceased alive on April 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert L. Krieger</i>		DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED April 31 1969			
22d. PHYSICIAN'S NAME (Type) Robert L. Krieger MD	22e. ADDRESS 7733 ALASKA AVENUE NW WASHINGTON DC 20012						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-6-69	23c. NAME OF CEMETERY OR CREMATORIAL MT. Lebanon Cemetery	23d. LOCATION (City or Town) HYATTSVILLE	(County) MARYLAND	(State)		
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASHINGTON - DC	ADDRESS BERNARD DANZANSKY & SONS - WASHINGTON - DC	25a. REC'D BY REGISTRAR APR 10 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Dodge</i>				

30 17

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05557

05551

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Ann	Middle Louise	Last BOWERS	2a. DATE OF DEATH Month April	Day 28	Year 69	2b. HOUR A 1020M	
3 SEX Female	4. RACE Caucasian	5. DATE OF BIRTH August 1, 1920			6. AGE (In years last birthday) 48	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery County					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Registered nurse		12b. KIND OF BUSINESS OR INDUSTRY School board		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Pr. George	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 4100 Kenny St.,				
14. FATHER'S NAME First Andrew	Middle Mikush	15. MOTHER'S MAIDEN NAME Louise	Middle Malick	Malick	Lost	Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. 1942-48	17. INFORMANT Beltsville	Address Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1929 DUE TO, OR AS A CONSEQUENCE OF Glioblastoma multiforme Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF lost (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION 27 Apr. 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Glioblastoma multiforme		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that <input checked="" type="checkbox"/> (the hospital) attended the deceased from Apr. 25, 1969, to Apr. 28, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Apr. 28, 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE Calvin B. Early, M.D., Ph.D.		22c. DATE SIGNED Apr. 30, 1969						
22d. PHYSICIAN'S NAME (Type) Calvin B. EARLY, MD PHD		22e. ADDRESS Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVALS Specify X X X CREMATION		23b. DATE 5/3/69	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory	23d. LOCATION (City or Town) Bladensburg, Pr. Geo.	(County)	(State) Md.		
24. FUNERAL DIRECTOR Name: E. PUMPHREY Funeral Home 8434 Georgia Ave., Silver Spring, Md.		25a. RECD BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				
VR AF 30M REV 6/68								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05552

05558

1. DECEASED NAME (Type or print)			First	Middle	Last	2d. DATE OF DEATH	2b. HOUR			
James Joseph Bradley						Month April	Day 25	Year 1969	8:40AM	
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDERR 1 YEAR				
Male		Caucasian	4-9-1888		81	MONTHS	MONTHS	IF UNDERR 24 HRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED		NEVER MARRIED	DAYS				
Maryland		U.S.A.	<input checked="" type="checkbox"/>		<input type="checkbox"/>					
9. COUNTY OF DEATH		WIDOWED		DIVORCED	HOURS					
Montgomery					MIN.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				
Kensington			Kensington Gardens			Machinist				
13a. USJAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Maryland			Lexington Park		YES <input type="checkbox"/> NO <input type="checkbox"/>	Box 78				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME				
William					Bradley	First Middle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
(If yes give war or dates of service)						James P Bradley				
						Address				
						6120 Old H Rd Chevy Chase				
						Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY			DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Vivarium Caisura inj- (b) DUE TO, OR AS A CONSEQUENCE OF (c)			years				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 4/3/1962 to 9-1-1964, that (I) (we) lost saw the deceased alive on 4-14-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
22d. PHYSICIAN'S NAME (Type) Abraham W. Danish, M.D.										
22e. ADDRESS										
1106 Spring Street, Silver Spring, Md.										
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 28, 1969	Ebenezer Cemetery		Great Mills, St. Mary's, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
McClary Wallingay Lanes and Town, Md.				APR 29 1969		Abraham J. Danish				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~executed~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 7 days after death.

222



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05559

CERTIFICATE OF DEATH

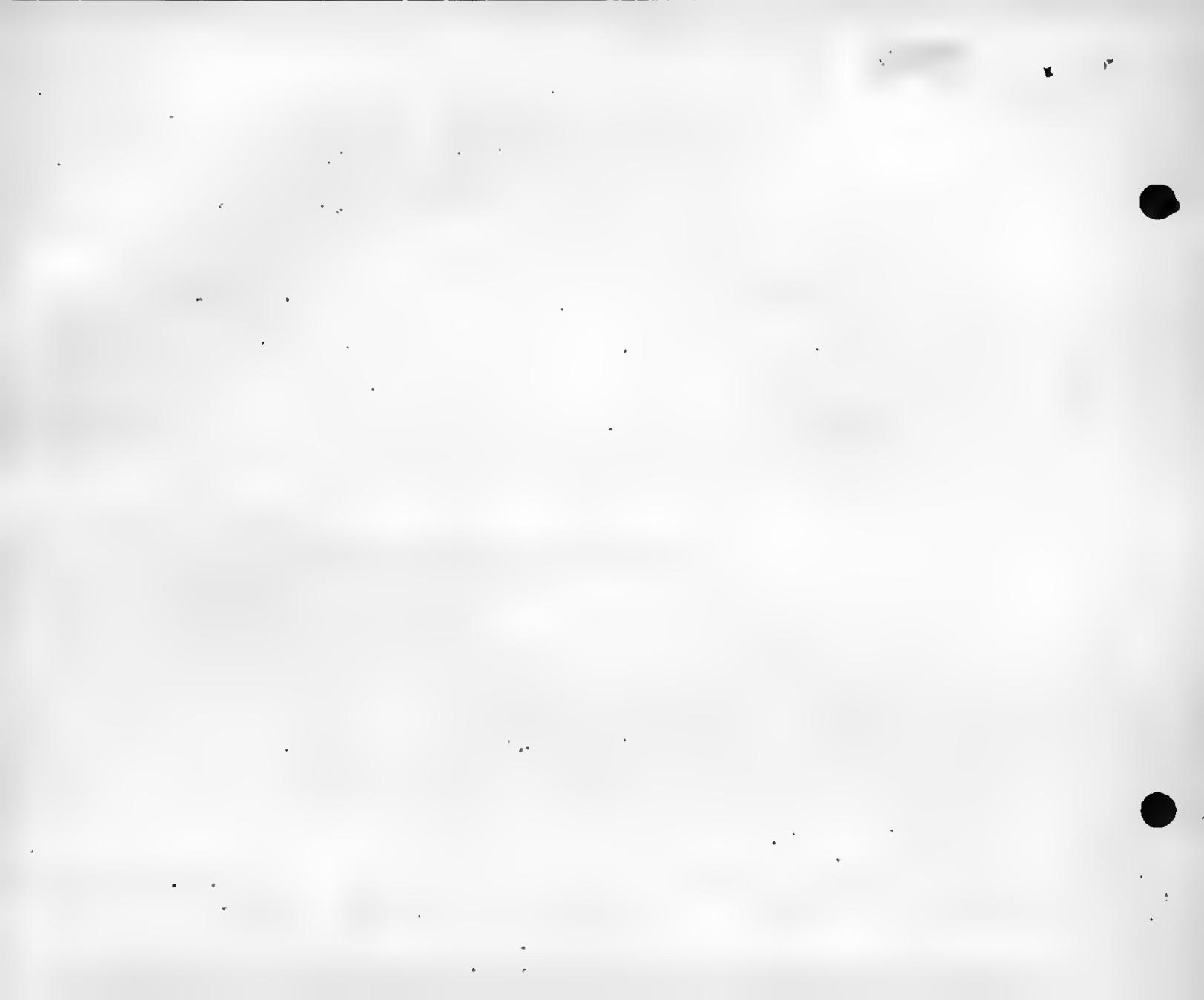
05553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Robert</i>	Middle <i>Joseph</i>	Last <i>Brennan</i>	2a. DATE OF DEATH Month <i>APRIL</i>	Day <i>2</i>	Year <i>1969</i>	2b. HOUR <i>8:30 AM</i>				
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>April 20, 1969</i>		6. AGE (In years last birthday) — yrs.		7. UNDER 1 YEAR MONTHS <i>2</i>		IF UNDER 24 HRS. HOURS <i>22</i>		MIN <i>13</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>						
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Hyattsville</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4204 Gallatin St.</i>						
14. FATHER'S NAME First <i>Robert</i>		Middle <i>Martin</i>	Last <i>Brennan</i>	15. MOTHER'S MAIDEN NAME First <i>June</i>		Middle <i>Allison</i>	Last <i>Dukes</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>		17. INFORMANT <i>mother</i>		Address <i>as above</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurity</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>lost.</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>April 20, 1969</i> , to <i>April 21, 19</i> , that (I) (we) last saw the deceased alive on <i>April 19, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Murray Paul</i>		22c. DEGREE <i></i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i></i>						
22d. PHYSICIAN'S NAME (Type) <i>Murray Paul</i>		22e. ADDRESS <i>1040 University Blvd. E. Langley Park</i>										
23a. BURIAL, CREMATION, BURIETAL (Specify) <i>Burial</i>		23b. DATE <i>2/25/69</i>		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION (City or Town) <i>Silver Spring, Md.</i>		(County) <i></i>		(State) <i></i>		
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		24b. ROCK. PINE <i>Rock. Pike</i>		24c. REC'D BY REGISTRAR <i></i>		24d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
VR A15 30M REV. 168												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05554

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

05560				Last				2a. DATE OF DEATH				2b. HOUR	
First Mary Middle Estelle Brown				Month April 26 Year 1969				IF UNDER 1 YEAR		IF UNDER 24 HRS.			
1. DECEASED NAME (Type or print)		2. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		MONTHS		DAYS		HOURS	
Female		White		May 29, 1878		90 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		Montgomery		Housewife		Own home			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12c. CITY OR TOWN		13e. STREET AND NUMBER							
Baltimore Md.		St. John's Nursing Home		Brookville		RE #1-Box 51 AA							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET AND NUMBER							
Maryland		Montgomery		Brookville		RE #1-Box 51 AA							
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S NAME	First	Middle	Last					
		George	E	Zuelie		Annie		Sullivan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		None		STANSBURY Brown, RE #1-Box 51 AA		Brookville, Md.		20 min					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 410 9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) coronary thrombosis 20 min stating the underlying cause (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized arteriosclerosis, semilute hypertension													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 2/27/69, 19, to 4/26/69, 19, that (I) (we) last saw the deceased alive on 2/27/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE Patrick Jameson		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 4/26/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		11718 Georgia Silver Spring Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Tues., Apr. 20 1969		23c. NAME OF CEMETERY OR CREMATORIAL Forest Glen		23d. LOCATION (City or Town) Silver Spring, Mont., Md.		(County)		(State)			
24. FUNERAL DIRECTOR John Carter, Glendale, 8434 Georgia Avenue Barber E. Purphrey, Inc., Silver Spring, Md.		ADDRESS		25a. REC'D. BY REGISTRAR APP 30 1969		25b. REGISTRAR'S SIGNATURE John's J. Carter							



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

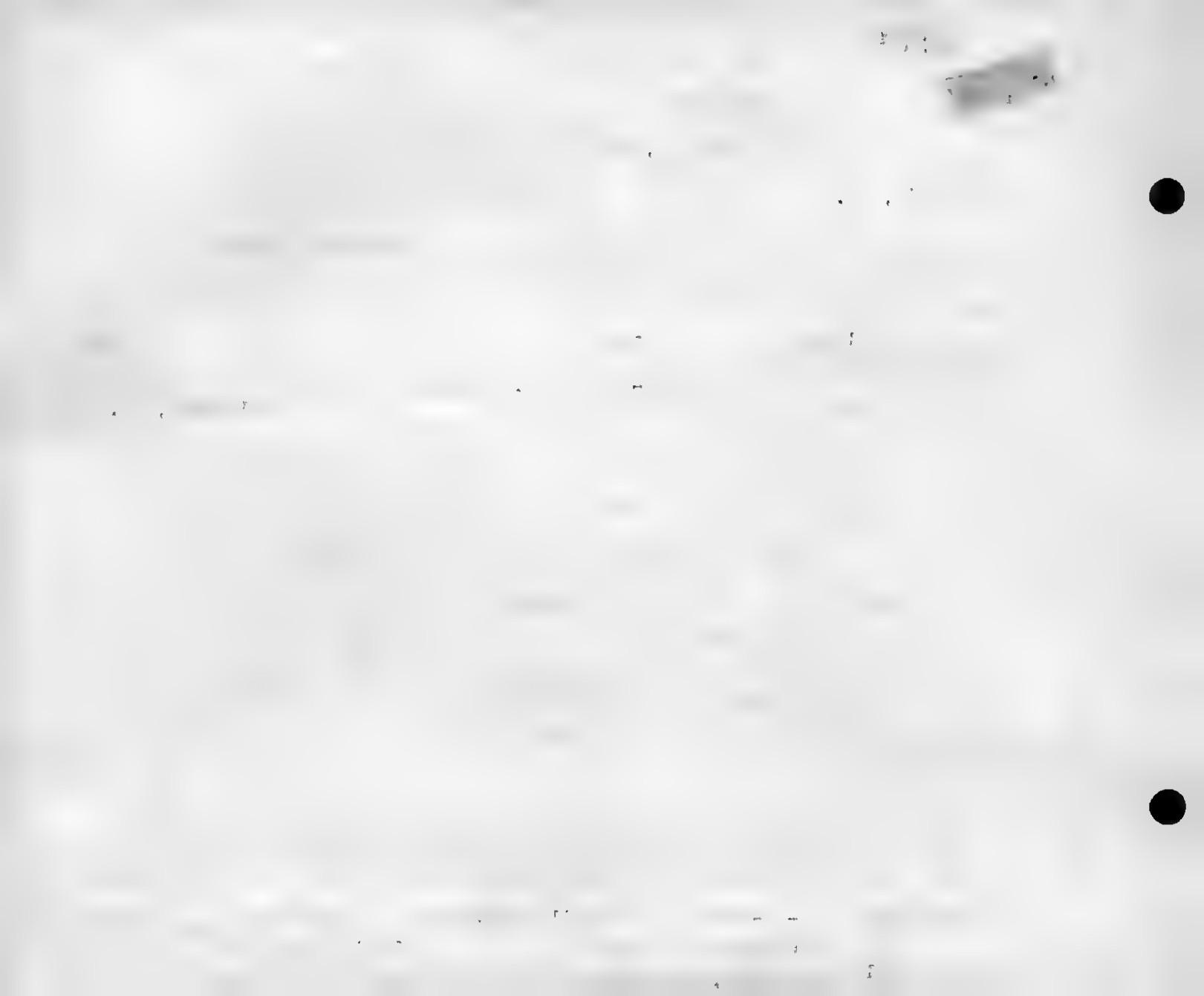
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 2a Film 414 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05561

05555

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	20. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR	
Violet Gertrude				Brown		X	4	16	69	11:25A	
3. SEX	4. RACE	5. DATE OF BIRTH	6 AGE (in years at time of death) YRS	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 IF UNDER 24 HRS HOURS	10c. DATE PRONOUNCED DEAD Monthly	Doy	Year	2d. HOUR	
F	W	October 30, 1917	71				16	16	69	M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
Cecil, Md.		USA				Montgomery					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San & Hosp			Practical Nurse					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Maryland			Montgomery		Takoma Pk	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7118 Willow Ave				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
William				Sauers						Fliger	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
no			232-26-0934			Mrs. Virginia Stauinger			10222 Falkirk Road Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ 47-X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause _____ DUE TO, OR AS A CONSEQUENCE OF pulmonary emphysema											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Reap</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED APRIL 16, 1969		
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 4-17-1969			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory			23d. LOCATION (City or Town) Suitland		(County) Maryland State
24. FUNERAL DIRECTOR			ADDRESS I331 Rockville Pike Tyson Wheeler Rockville, Maryland			25a. REC'D BY REGISTRAR DATE APR 18 1969			25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05562

05556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~exhibited~~ within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH 4 30		2b HOUR 4:45 P.M.	
ELIZABETH CLARICE BRYAN								
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 3/1/96		6. AGE (in years last birthday) 12 yrs.		
7.0. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Md		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res.dence before admission) STATE MARYLAND		13b. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMIT? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 3716 GREENCASTLE ROAD		
14. FATHER'S NAME CLARENCE		15. MOTHER'S MAIDEN NAME ELIZABETH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Breast - widespread								
DUE TO, OR AS A CONSEQUENCE OF (b) Metastases Bone, Liver, Lung								
DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Pneumonia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
MEDICAL CERTIFICATION								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from May 19, 1964 to May 19, 1964 , that (I) (we) last saw the deceased alive on May 19, 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Joseph E. Smith, Jr.</i>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22e. DATE SIGNED		
22e. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr.		22f. ADDRESS Baltimore, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 2, 1964		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		
24. FUNERAL DIRECTOR <i>Arthur Nather</i>		ADDRESS 254 Carroll St. DC		25a. REC'D BY REGISTRAR DMV 1 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. Geiger</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05563

05557

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Columbus</i>	Middle <i>VINCENT</i>	Last <i>BRYANT</i>	2a. DATE OF DEATH Month <i>April</i>	Day <i>20</i>	Year <i>1969</i>	2b. HOUR <i>6:59 A.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>12/18/83</i>	6. AGE (In years last birthday) <i>8</i>	7. IF UNDER 24 HRS MONTHS <i>0</i>	YEAR DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>PET-PLANER OPERATOR PA. R.R.</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>					
13a. JEWEL RESIDENCE (Where deceased lived, if institution residence before admission). STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>8718 Coopers St. Apt. 216</i>				
14. FATHER'S NAME <i>George H. Bryant</i>	First <i>—</i>	Middle <i>—</i>	Last <i>—</i>	15. MOTHER'S MAIDEN NAME <i>Estelle</i>	Middle <i>—</i>	Last <i>Rock</i>	Address <i>Wheaton, Md.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i>	16b. SOCIAL SECURITY NO <i>D16-03-0984</i>	17. INFORMANT <i>James V. BRYANT - Son - WHEATON, MD.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <i>41d3</i> (b) <i>Arteriosclerotic Coronary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>Liver cirrhosis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/19</i> , 1969, to <i>4/20</i> , 1969, that (I) (we) last saw the deceased alive on <i>4/19</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Ronald W. Barr, MD</i>								
22d. PHYSICIAN'S NAME (Type) <i>Ronald W. Barr</i>		22e. ADDRESS <i>10401 Old Georgetown Rd, Bethesda</i>		22f. DATE SIGNED <i>4/20/69</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4/23/69</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND, MD.</i>		
24. FUNERAL DIRECTOR <i>Jos. GAWLER'S SONS, WASHINGTON, D.C.</i>		ADDRESS <i>5130 WISCONSIN AVE.</i>		25a. RECD BY REGISTRAR DATE <i>APR 23 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Wanda Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05558

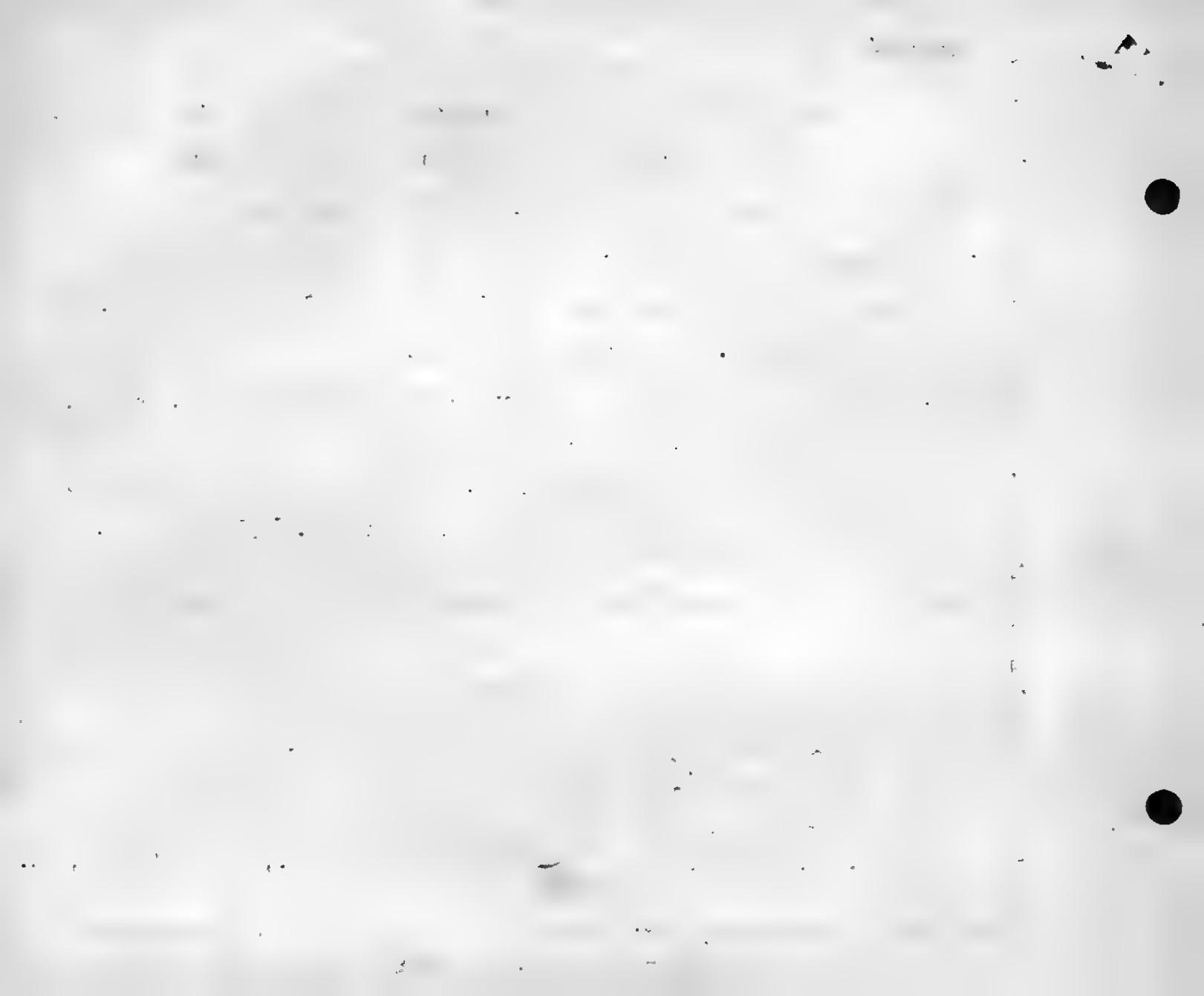
05564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER (DR. ROGERS COVERING FOR DR. REAP)

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
		Inez		Bryson	Month	Doy	Year	3:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH					
Female		White		9/21/13					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		6. AGE (In years last birthday)			
New York		USA		NEVER MARRIED	<input type="checkbox"/>	55	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				WIDOWED	<input checked="" type="checkbox"/>	S.	MONTHS	DAYS	
				DIVORCED	<input type="checkbox"/>	YEARS	HOURS	MIN	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
New York		?		Oneonta NY	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	818 E Jefferson St. Rock Md		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Last
		Raymond D.	O Day		Inez		son	Le Roy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
none				son Frank		818 E Jefferson St. Rock Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Pulmonary Emboli</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>Thrombophlebitis</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <i>Adeno carcinoma of Breast</i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
1 day									
sew wks									
17 mos									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) <i>(his hospital)</i> attended the deceased from <i>June 1968</i> , to <i>4/9 1969</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>4/9 1969</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death.									
22b. SIGNATURE <i>G. Lennard Gold</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4/9/69</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS					
G. Lennard Gold		9801 Georgia Ave., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) Kimbles, Pennsylvania		(County) (State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Rockville, Md.		ADDRESS		25a. REC'D BY REGISTRAR PAPER 14 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. Gold</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05565

05559

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>LEONP</i>	Middle <i>P</i>	Last <i>BUFFALOE</i>	20. DATE OF DEATH Month <i>APRIL</i>	Year <i>1969</i>	2b. HOUR <i>608 PM</i>
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>9/10/98</i>		6. AGE (in years last birthday) 70 YRS.		
7a. BIRTHPLACE (State or foreign country) <i>TENN</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i>		
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Babysitter</i>		12b. KIND OF BUSINESS OR INDSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4221 DRESDEN St.</i>	
14. FATHER'S NAME First <i>STEWART J.ICKARD</i>		Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>FRANCES</i>		Middle <i></i>	Last <i>ESCLIE</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>410-26-8669</i>		17. INFORMANT <i>MARTHA JANICE Rooney - DAUGHTER</i>		Address <i>Same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> / DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) (b) <i>Unknown</i> <i>year</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>calcification of uterus</i> <i>year</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>4-2, 1969</i> , to <i>4-9, 1969</i> , that (I) (we) last saw the deceased alive on <i>4-9, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Sarah E. Glover, M.D.</i>		22c. DATE SIGNED <i>4-10-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Sarah E. Glover, M.D.</i>		22e. ADDRESS <i>10128 CEDAR LANE KENSINGTON MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/14/1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gates Cemetery</i>		23d. LOCATION (City or Town) <i>Gates</i>	(County) <i>Tenn.</i>	(State)
24. FUNERAL DIRECTOR <i>TYSON WHEELER FUNERAL HOME Rockville, Md.</i>		25a. ADDRESS <i>1720 ROCKVILLE Pike</i>		25c. REC'D BY REGISTRAR <i>APR 14 1969</i>		25b. REC'D BY REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05566

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN <input checked="" type="checkbox"/> ESTI. DEATH MATED	Month	Day	Year	2b HOUR	
<i>ANNA</i>		<i>M</i>	<i>BYRNE</i>		<input checked="" type="checkbox"/>	<i>4</i>	<i>11</i>	<i>69</i>	<i>3 P M</i>	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month			2d HOUR	
<i>Female</i>	<i>W</i>	<i>12/05/91</i>	<i>97 70 yrs</i>			<i>april</i>	<i>11</i>	<i>1969</i>	<i>3 P M</i>	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH					
<i>Ireland</i>		<i>U.S.A.</i>			<i>Montgomery</i>					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
<i>Bethesda</i>		<i>Suburban Hospital</i>		<i>Housewife</i>			<i>AT HOME</i>			
13a USUA. RESIDENCE (Where deceased lived, if inst tut on Residence before admission) STATE		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			13e STREET AND NUMBER			
<i>La.</i>		<i>Rapides Pineville</i>		<input type="checkbox"/> YES <input type="checkbox"/> NO			<i>2100 Expressway</i>			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
<i>James</i>		<i>Owen</i>	<i>McLaughlin</i>	<i>Jane</i>	<i>Nellie</i>			<i>M. Illenay</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT			ADDRESS			
<i>No</i>		<i> </i>		<i>Nellie (daughter) Mrs Brown, Reese Beth, Md</i>			<i>5423 London Ct.</i>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4123</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost										
DUE TO, OR AS A CONSEQUENCE OF <i>Acute Coronary Insufficiency</i> <i>Arteriosclerotic Heart Disease</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY?					
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				<i>19</i>						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS <i>Street, town, city or county</i>										
22b DATE SIGNED <i>APRIL 11, 1969</i>										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)
<i>BURIAL</i>		<i>4-12-69</i>					<i>NEW ORLEANS</i>			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
<i>W.W. Chambers Co</i>		<i>Silver Spring Md.</i>		<i>APR 18 1969</i>			<i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05567

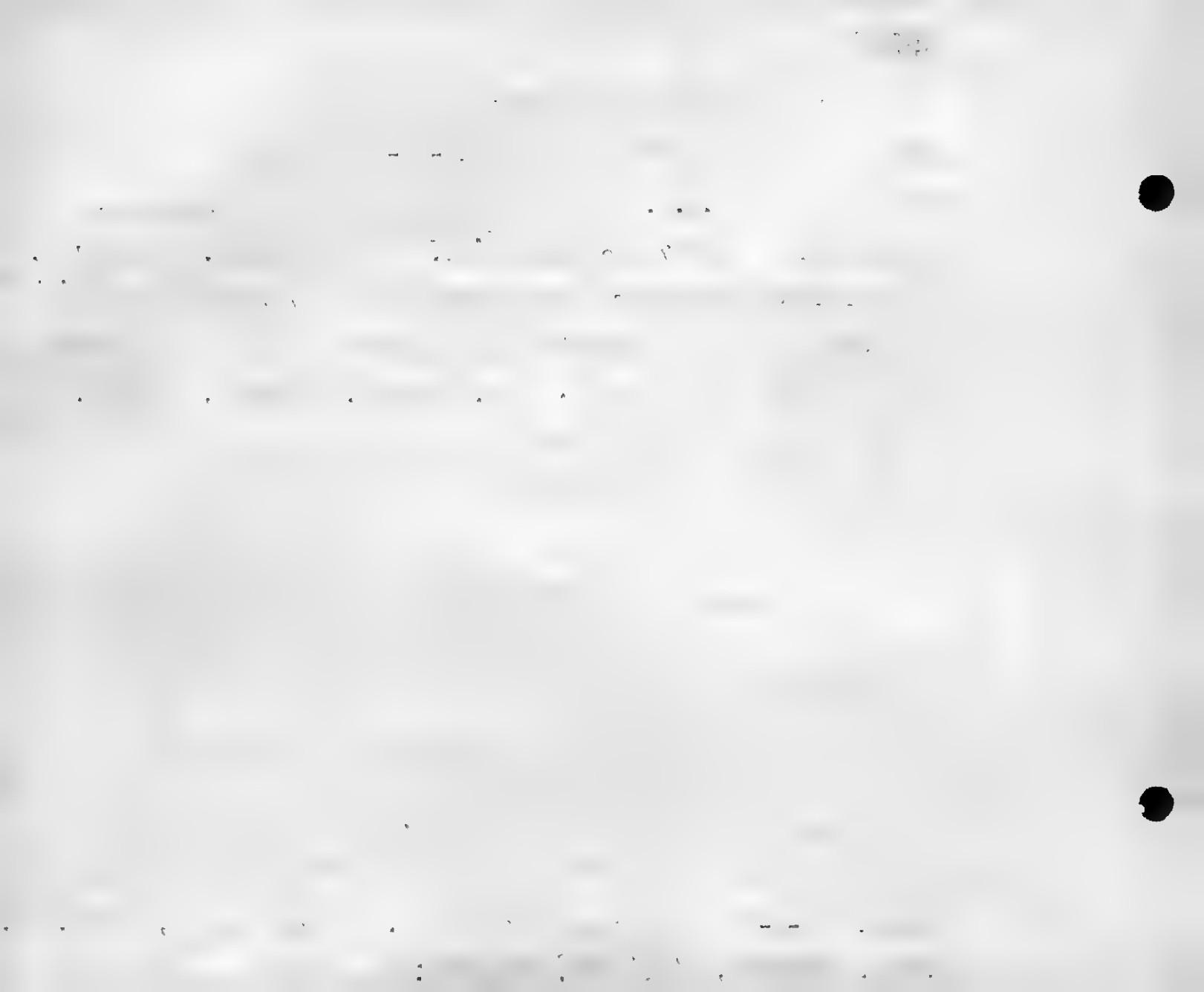
05561

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First JAMES ANTHONY	Middle CAMPBELL	Lost	2a. DATE OF DEATH 4 Month 38 Day 69 Year	2b. HOUR 6 30 A.M.
3. SEX Male		4. RACE White	S. DATE OF BIRTH 10-24-99	6. AGE (in years last birthday) 69	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS MONTHS DAYS HOURS MIN. 0 0 0 0
7b. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (Not in hospital 9c street address) Apt. 219 4757 Chevy Chase Dr.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Office Mgmt.	12b. KIND OF BUSINESS OR INDUSTRY Acc'tg.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13c. CITY OR TOWN Chevy Chase X	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 4757 Chevy Chase Drive		
14. FATHER'S NAME Felix		15. MOTHER'S MAIDEN NAME Campbell	Hanna	Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO ***	17. INFORMANT Mrs. Helen A. Campbell,	Address Address as above.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1407		Malnutrition				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b.		DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis				
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1969 , to April 28, 1969 , that (I) (we) last saw the deceased alive on April 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Dr Joseph P. Kenrick		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 4/28/69	
22d. PHYSICIAN'S NAME (Type) Dr JOSEPH P. KENRICK		22e. ADDRESS 4450 Wisconsin Ave, Bethesda, Md.				
23a. BLR A. CREMATON ON, REMOVAL (Specify) Burial		23b. DATE 5-1-69	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.	23d. LOCATION (City or town) Silver Spring, Montg. Md.	(County)	(State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY,		ADDRESS 7557 Wisconsin Ave, Bethesda, Maryland	25a. RECD BY REGISTRAR MAY 5 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		



05568

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05562

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First EMMA	Middle Florence	Last CARMACK	2a. DATE OF DEATH Month April	Day 11	Year 1969	2b. HOUR 11 45 P.M.	
3 SEX Female	4 RACE White			S. DATE OF BIRTH October 10, 1879	6. AGE (in years last birthday) 89 YRS		IF UNDER 1 YEAR MONTHS 0		
7b. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY		
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13e. STREET AND NUMBER 10019 Kinross Avenue					
14. FATHER'S NAME First Hezekiah		Middle 	Last Magruder	15. MOTHER'S MIDDLE NAME First Ella Whittington					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-56-4646		17. INFORMANT Emma V. Carmack-10019 Kinross Ave. Pvt Chart Silver Spring, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> 4 10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiomegaly - arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Senility atrial fibrillation</i></p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
<p>22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>April 10 1969</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>Philip E. Jones M.D.</i>		DEGREE <input checked="" type="checkbox"/> MED ATTENDING PHYS. <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/12/69</i>						
22d. PHYSICIAN'S NAME (Type) <i>Philip E. Jones M.D.</i>		22e. ADDRESS <i>800 Pershing, Silver Spring, Md. 20910</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/14/69	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn		23d. LOCATION (City or Town) Rockville, Md.		(County)	(State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		ADDRESS		25a. REGD BY REGISTRAR DATE APR 15 1969		25b. REGISTRAR'S SIGNATURE <i>Jessie J. Jones</i>			



05569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05563

FOR STATE
HEALTH DEPT.

~~TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Page 5 may be retained for your files.~~

~~TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.~~

1. DECEASED-NAME (Type or Print)		First Orland	Middle	Last Carra Sr.	2a DATE KNOWN OF ESTI. DEATH MATED	Month 4	Day 18	Year 1969	2b. HOUR M
3 SEX <input checked="" type="checkbox"/> M	4. RACE <input type="checkbox"/> W	5. DATE OF BIRTH 12-5-1923	6 AGE (in years last birthday) 15 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURLS 0	MIN 0	2c. DATE PRONOUNCED DEAD Month 4	2d. HOUR Day 21
7a BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital g vs res addressee) 9126 Sycamore Ave.			12a USUAL OCCUPATION (Kind of work done during last year, even if retired) Tak Clerk			12b KIND OF BUSINESS OR INDUSTRY B & O RR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b COUNTY Montgomery	13c. CITY OR TOWN Takoma Pk.	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 7126 Sycamore Ave. T.P., Md.					
14. FATHER'S NAME James P. Carra	First Middle Last	15. MOTHER'S MAIDEN NAME Anna Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes	16b. SOCIAL SECURITY NO. WW II	17. INFORMANT Orland Carra, Jr. 2699 Dulaney St. Balto 21223	ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 485X Pneumonia, lobular, extensive DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> BELDEN R. REAP M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED APRIL 21, 1969		
23a. BUR. A. CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-69	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National			23d. LOCATION (City or Town) (County) Balto. City Baltimore Md.		(State)	
24. FUNERAL DIRECTOR		ADDRESS Howard H. Hubbard 4107 Wilkens Avenue 21229			25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE James J. Geage		

$\frac{d}{dt}$

β

α

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05570

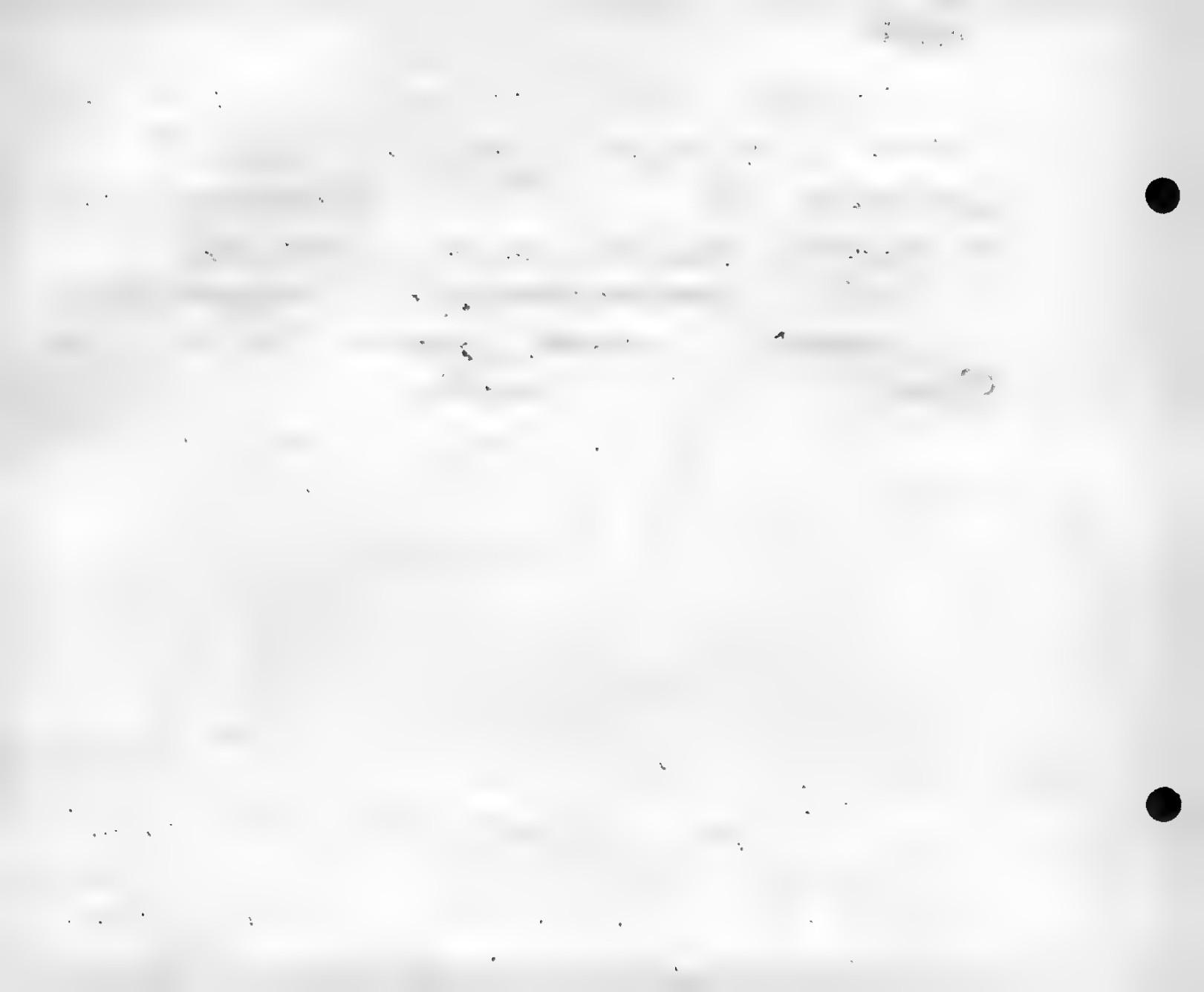
05564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
LEONARD FULTON CAUDLE				Month 4 Day 28 Year 69	5 ⁰⁰ AM
3. SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	If UNDER 1 YEAR MONTHS DAYS HOURS MIN
MALE	CAUCASIAN	12/1/31		37 88 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	
NORTH CAROLINA	USA			MONTGOMERY COUNTY, Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
SILVER SPRING	HOLY CROSS HOSPITAL			TRUCK DRIVER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY	
N. C.	MECKLENBERG CHARLOTTE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9067 ORE STREET		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
LEONARD C. CAUDLE (deceased)				OZELLE POTTS CAUDLE	
16a. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes/no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
ARMY		Mother			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) Acute Myocardial INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Artherosclerotic Heart Disease					
DUE TO, OR AS A CONSEQUENCE OF (b) Artherosclerotic Heart Disease					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 4/26/69 to 4/28/69 , that <input type="checkbox"/> (we) last saw the deceased alive on 4/22/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did not) view the body after death.					
22b. SIGNATURE W. Hubbard					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED 4/28/69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-30-69	23c. NAME OF CEMETERY OR CREMATORIUM Sharon Memorial Park		23d. LOCATION (City or Town) (County) (State) Charlotte, North Carolina
24. FUNERAL DIRECTOR		ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR APR 30 1969	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Anna Mae	Middle Cecil	Last	2a. DATE OF DEATH Month April Year 1969 2b. HOUR 2 AM			
3. SEX F	4. RACE W	5. DATE OF BIRTH 7-4-79	6. AGE (in years last birthday) 89 yrs	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery	10. CITY OR TOWN OF DEATH Rockville			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Md.	13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. CITY OR TOWN Montgomery Gaithersburg	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route 3	
14. FATHER'S NAME First John	Middle Fisher	15. MOTHER'S MARRIED NAME First Mary	Ryan	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO.	17. INFORMANT Rodger Flynn, Bethesda, Md. Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i>				DUE TO, OR AS A CONSEQUENCE OF 6 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>							
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , to <i>April 21, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 10, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen C Cromwell MD</i>				ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>April 28, 1969</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>615 W. Montgomery, Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <i>4-30-69</i>	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	23d. LOCATION (City or Town) Houston	(County) Texas	(State)	
24. FUNERAL DIRECTOR Robert A Pumphrey 7557		ADDRESS Wisconsin Ave Bethesda, Md.	25a. REC'D BY REGISTRAR DATE 1969 5	25b. REGISTRAR'S SIGNATURE <i>Charles J. Dugan</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05572

05566

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Boxes 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR Min	
<i>Eunice F. Claffin</i>				<i>April 24, 1969</i>			<i>4:30 P.M.</i>	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE IN YEARS Last b		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
<i>Female</i>	<i>white</i>	<i>Aug 6, 1875</i>		93				
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			Md	
<i>Wisconsin</i>	<i>U.S.A.</i>		<i>Montgomery</i>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Bethesda</i>	<i>Suburban</i>			<i>Housewife</i>			<i>Housingwood</i>	
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
<i>Md.</i>	<i>Mont.</i>	<i>Cherrydale</i>	<i>YES</i>	<i>7303 - Rollingwood</i>				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<i>Albert M. Cops.</i>				<i>Clarendon Florence Chandler</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO.			17. INFORMANT			Address <i>Dorothy Deitrich 7303 Rollingwood</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11-7</i> hours								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis with myocardial infarction.</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 1950</i> , to <i>APRIL 1969</i> , that (I) (we) last saw the deceased alive on <i>4/22 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John J. Donovan</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>4/25/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>DR. JOHN J. DONOVAN</i>		22e. ADDRESS <i>8218 WISC AVE BETHESDA MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 28, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek</i>			23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON DC</i>		
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS 5130 WISC. AVE NW D.C.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05567

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	20. DATE OF DEATH Month Day Year	2b. HOUR
<i>Donald E. Clark</i>				April 22, 1969 11:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.
<i>MALE</i>	<i>White</i>	<i>Nov. 21, 1896</i>	<i>72 yrs</i>		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH		
<i>Maryland</i>	<i>U.S.A.</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Montgomery</i>		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
<i>Silver Spring Holy Cross Hospital</i>				<i>Retired-U.S. Gov't.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
<i>Maryland</i>	<i>Montgomery</i>	<i>Silver Spr.</i>	<i>NO</i>	<i>101-FRANKLIN AVENUE,</i>	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
<i>Franklin P. Clark</i>				<i>Caroline V. Scholl</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
<i>Yes</i>	<i>World War I</i>	<i>213-44-7039</i>	<i>Donald R. Clark (Son) Same as #13</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Emphysema</i>					
DUE TO, OR AS A CONSEQUENCE OF <i>with abscess formation</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bilat. confluent necrotizing bronchopneumonia</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic pulmonary fibrosis and emphysema</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (his-hospital) attended the deceased from <i>3-31, 1969</i> to <i>4-22, 1969</i> , that (I) (we) last saw the deceased alive on <i>4-22, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>JASON GEISER, MD</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED-DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4-22-69</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>800 AEROSPACE DRIVE SILVER SPRING</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-24-69	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>	23d. LOCATION (City or Town) <i>Silver Spring, Maryland</i>	(County)	(State)
24. FUNERAL DIRECTOR Francis J. Collins	ADDRESS 500 Univ. Blvd. West. Silver Spring, Maryland	25a. REC'D BY REGISTRAR APR 25 1969	25b. REGISTRAR'S SIGNATURE <i>James George</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05568

1 05574				2a. DATE OF DEATH Month 4 Day 15 Year 69				2b. HOUR 3:06 PM		
1. DECEASED NAME (Type or print)		First Hester.	Middle Flournoy	Last Clarke						
3. SEX F		4. RACE W		5. DATE OF BIRTH ***** 2-2-84		6. AGE (In years 16 ^b birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY P.C.		13c. CITY OR TOWN Hyatts,		13d. INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2413 Griffin St.		
14. FATHER'S NAME First John		Middle Clift	Last	15. MOTHER'S MAIDEN NAME First Nannie		Middle	Last Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO		17. INFORMANT Mrs Dorothy white (Dr) Same		Address				
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF Mayocardiac dysfunction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes				
Conditions, if any, wh.ch gave rise to immediate cause (a), stating the underlying cause last		(b) DUE TO, OR AS A CONSEQUENCE OF A S H O .				5 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 4/12/1969, that (I) (we) last saw the deceased alive on 4/12/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Hugh J. Irey, M.D.</i>		22c. DEGREE M.D.		ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTDR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED 4/13/69		
22d. PHYSICIAN'S NAME (Type) Hugh J. IREY, M.D.		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 16, 1969		23c. NAME OF CEMETERY OR Crematory Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland Pro Geo		(County) Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05569

05575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First James	Middle Edward	Last Cleamons	2a. DATE OF DEATH Month April	Day 26	Year 1969	2b. HOUR 4:45 P.M.	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH May, 10, 1901		6. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR MONTHS 6		IF UNDER 24 HRS HOURS 4	
7a. BIRTHPLACE (State or foreign country) Washington, D. C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farm Worker		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res dence before admission) STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN H. Friendship	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER Route 2				
14. FATHER'S NAME Arthur	First Cleamons	Middle Ida	Last Bacon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No	16b. SOCIAL SECURITY NO (If yes give no. or dates of service)	17. INFORMANT Records	Address Montgomery General Hospital, Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PULMONARY EDEMIT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) CHRONIC MYOCARDIAL FAILURE stating the underlying cause last (c) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HOURS 2 4 YEARS								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BLVCS IN PNEUMONIA								
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner) <input type="checkbox"/> Cause of death <input type="checkbox"/> Not cause of death	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —						
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —	21f. LOCATION Street or R.F.D. No. —	City or Town —	County —	State —			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/26 1969 , and that in (my) his opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.								
22b. SIGNATURE Charles S. Whitaker, M.D.	22c. DEGREE B.S.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 4/26/69			
22d. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.	22e. ADDRESS Clarksville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4-30-69	23c. NAME OF CEMETERY OR CREMATORIAL St Luke Cemetery	23d. LOCATION (City or Town) (County) Liberville	(State) Md.				
24. FUNERAL DIRECTOR Harry W. Haughey	ADDRESS 4 Kosciusko St., Clarksville, Maryland	25a. REC'D. BY REGISTRAR DATE MAY 2 1969	25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 1c. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

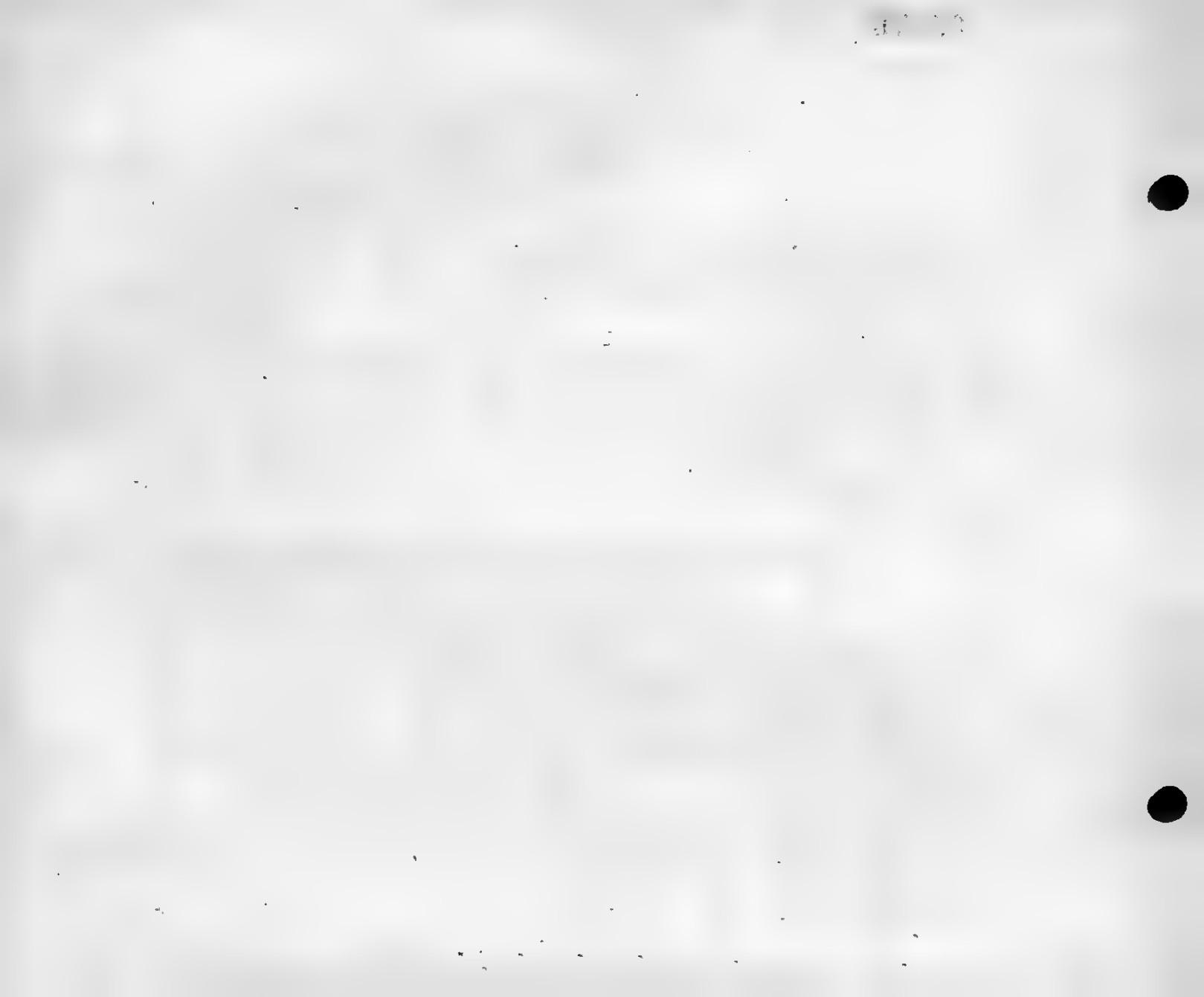
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
05576 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05570

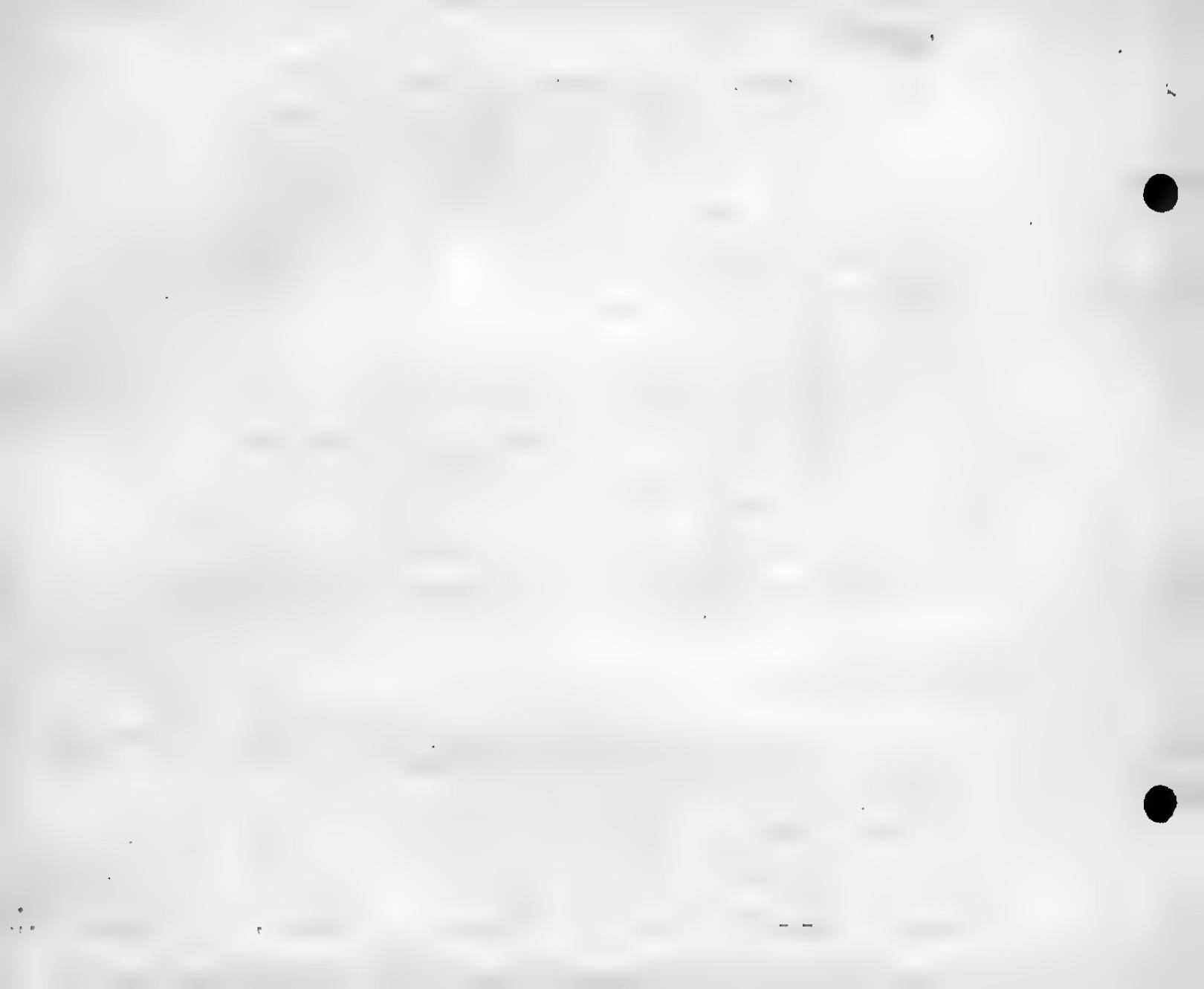
1. DECEASED NAME (Type or Print)	First ANNA	Middle Marie	Last COBB	2a. DATE KNOWN Month Day Year	2b. HOUR
3. SEX F	4. RACE W	5. DATE OF BIRTH 5/18/85	6. AGE (in years last birthday) 83 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Oregon	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery County	10c. DATE PRONOUNCED DEAD Month Day Year	12d. HOURS am
10. CITY OR TOWN OF DEATH Silver Spring., Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) seamstress	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? NO	13e. STREET AND NUMBER 10604 Glenhaven Dr.	12b. KIND OF BUSINESS OR INDUSTRY
14. FATHER'S NAME First Henry	Middle Lasfolk	15. MOTHER'S MAIDEN NAME First unknown	Middle unknown	Last Maryland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 541-12-6700	17. INFORMANT Silver Spring	ADDRESS Wesley Cobb-10604 Glenhaven Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerotic Heart Disease. lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden R. Peay</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>April 5, 1969</i>	
EXAMINER'S NAME (Type) BELDEN R. PEAY, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 7, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d. LOCATED ON (City or Town) Rockville, Maryland	(County)	(State)
24. FUNERAL DIRECTOR John Carter	ADDRESS Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil. Md.		25a. REC'D BY REGISTRAR APR 11 1969	25b. REGISTRAR'S SIGNATURE Wm. J. Judge	



18
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First <u>Samuel</u>	Middle <u>Francis</u>	Last <u>Cole</u>	2d DATE OF DEATH Month <u>April</u> Doy <u>30</u> Year <u>1969</u>			2b HOUR <u>6 P.M.</u>				
3. SEX <u>Male</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>11/17/85</u>			6. AGE (In years last birthday) <u>83</u> YRS.		7. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN <u>0</u>				
7a. BIRTHPLACE (State or foreign country) <u>West of Columbia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>			10. CITY OR TOWN OF DEATH <u>Bethesda</u>				
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Tuberculosis sanatorium</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <u>private</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>								
13a. US-JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>D.C.</u>		13b. COUNTY <u>-</u>		13c. CITY OR TOWN <u>D. C.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>3701 - 6th Ave. N.W.</u>					
14. FATHER'S NAME <u>Marcellus</u>		Middle <u>cole</u>	Last <u>cole</u>	15. MOTHER'S MAIDEN NAME First <u>Phoebe</u>		Middle <u>Heene</u>	Last <u>J. Cole</u>	Address <u>Dr. J. L. Spingold</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO <u>59-60-4746</u>		17. INFORMANT <u>Henry J. Cole, Son</u>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4369</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute cerebro-vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>1) Hypertension 2) Emphysema 3) Arteriosclerosis 4) Diabetes Mellitus</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) (At home, farm, street, factory, off ce building etc.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>October, 1965</u> , to <u>April, 1969</u> , that (I) (we) last saw the deceased alive on <u>29 April, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>C. Roger Kurtz, M.D.</u>		22c. DEGREE <u>M.D.</u>		ATTENDING PHYS <u>X</u>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22d. DATE SIGNED <u>4/30/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>		22e. ADDRESS <u>3101 Church Avenue, Beltsville, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-3-1969</u>		23c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) <u>Suitland, Prince Georges Co., Md.</u>		(County)		(State)			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. ADDRESS 8190 W. ST. AVE., N. W. WASH., D. C. 20016						25a. RECD BY REGISTRAR DATE <u>MAY 6 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Patricia J. Cole</u>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05578

05572

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Eugene S. Collins</i>	Middle <i>S.</i>	Last <i>Collins</i>	2a. DATE OF DEATH Month <i>April</i>	Year <i>1969</i>	2b. HOUR <i>1245 PM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>1/10/83</i>		6. AGE (in years last birthday) <i>86</i>	IF UNDER 1 YEAR MONTHS <i>86</i>	IF UNDER 24 HRS. HOURS <i>00</i>
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Co.</i>		
10. CITY OR TOWN OF DEATH <i>Sil. Spr. Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Aetna Gar. (Retir.)</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>9702 Woodland Drive</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Mont. Co.</i>	13c. CITY OR TOWN <i>Sil. Spr.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>9702 Woodland Drive</i>		
14. FATHER'S NAME First <i>William</i>	Middle <i>Patrick</i>	Last <i>Collins</i>	15. MOTHER'S MAIDEN NAME First <i>Ellen</i>	Middle <i>McDermott</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>202-44-0748</i>	17. INFORMANT <i>Mrs. Naomi T. Collins (wife)</i>	Address <i>Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Coronary Occlusion</i> DUE TO, OR AS A CONSEQUENCE OF lost. (b) <i>Coronary Artery Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> (c) <i>4 months</i> <i>years</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>4426169</i>	City or Town <i>Laurel</i>	County <i>Prince George's</i>	State <i>Md.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/24/69</i> , to <i>4/26/69</i> , that (I) (we) last saw the deceased alive on <i>4/26/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <i>Bolen J. Curry M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/26/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>JOHN J. CURRY, M.D.</i>	22e. ADDRESS <i>9801 Georgia Court</i>					
23a. BURIAL, CREMATION, BENEFICIAL (Specify) <i>Burial</i>	23b. DATE <i>4-29-69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>	23d. LOCATION (City or Town) <i>Silver Spring</i>	(County) <i>Maryland</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Scott's Funeral Pct. 8244 M.D.</i>	ADDRESS <i>1440 Scott's Funeral Pct. 8244 M.D.</i>	25a. REC'D BY REGISTRAR <i>Charles J. Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>			

65



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05579

05573

Item 1 filed 4/22/69 kk

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>69</u>	2b. HOUR <u>11:10 P.M.</u>
<i>Raymond Odemell Collins</i>					
3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>Nov 5, 1880</i>	6. AGE (in years last birthday) <i>88 yrs</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	Md.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9505 Worth Avenue</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Butcher</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Butcher</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>9505 Worth Ave.</i>	
14. FATHER'S NAME First <i>Charles Henry</i>	Middle <i>Collins</i>	Last <i>Collins</i>	15. MOTHER'S MAIDEN NAME First <i>Anna Elizabeth</i>	Middle <i>Oppenheimer</i>	Last <i>Oppenheimer</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <i>No</i>	16b. SOCIAL SECURITY NO. <i>220-46-7926</i>	17. INFORMANT <i>Mrs. Ethel Collins</i>	Address <i>9505 Worth Ave., Silver Spring, Md.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Secondary Anemia</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <i>Secondary Anemia</i>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <i>Carcinoma of prostate gland</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<i>Osteoarthritis, Arthritis + Senility</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <i>19</i> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>820</i>	City or Town <i>Washington, D.C.</i>	County <i>District of Columbia</i>	State <i>D.C.</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>May 20, 1968</i> , to <i>April 11, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 4, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Philip E. Jones M.D.</i>					
22d. PHYSICIAN'S NAME (Type) <i>Philip E. Jones M.D.</i>	22e. ADDRESS <i>820 Wisconsin Avenue</i>	22c. DATE SIGNED <i>4/11/69</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/14/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln</i>	23d. LOCATION (City or Town) <i>Washington, D.C.</i>	(County) <i>District of Columbia</i>	(State) <i>D.C.</i>
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS Inc.</i>	ADDRESS <i>8200 Georgia Ave.</i>	25a. REGD. BY REGISTRAR <i>APR 18 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
05580

05574

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Nellie Jewell Cook				2a. DATE OF DEATH Month April Doy 5, 1969			2b. HOUR P.M. 2:15		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 29, 1877		6. AGE (in years lost birthday) 91 yrs		IF UNDER 1 YEAR MONTHS 91 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Germantown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Marylander Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE District of Columbia		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 3314 Tenneyson St. N.W.			
14. FATHER'S NAME First William Middle G. Last Jewell		15. MOTHER'S MAIDEN NAME First Sarah Middle Isabelle Last Brill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO		17. INFORMANT Jerry L. Cook, Damascus, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years			
4124 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 8/13/57 , to 4/15/69 , that (I) (we) last saw the deceased alive on 4/13/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James P. Kerr, M.D.		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/6/69			
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22e. ADDRESS Damascus, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 8, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION (City or Town) Suitland, Md.		(County) (State)	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		ADDRESS		25a. REGD BY REGISTRAR DATE APR 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05575

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First xxxxxx P. Michael	Middle xxxxxx	Last Cook	2a. DATE OF DEATH Month April	Day 27	Year 69	2b. HOUR 11 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 6/13/98		6. AGE (In years last birthday) 70 YRS.			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Wash DC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Co.				
10. CITY OR TOWN OF DEATH Sil. Sprg Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Mont. Co.	13c. CITY OR TOWN Sil. Sprg Md.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8601 Manchester Road				
14. FATHER'S NAME Michael J. Cook	15. MOTHER'S MAIDEN NAME Katherine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. World I	16c. INFORMANT Mrs. P. Michael Cook	Address Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Esophageal carcinoma of Oropharynx was due to, or as a consequence of, metastasis to 1) Liver, 2) Left + clavicular node, 3) Mediastinal + lymph nodes.</i> Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost.								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis to 1) Liver, 2) Left + clavicular node, 3) Mediastinal + lymph nodes.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/14/69</i> , to <i>4/27/69</i> , that (I) (we) last saw the deceased alive on <i>4/26/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.								
22b. SIGNATURE <i>Albert H. Grollman</i>	ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4/27/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>ALBERT H. GROLLMAN</i>	22e. ADDRESS <i>1106 Spring St. Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-30-69	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION (City or Town) Silver Spring	(County) Maryland	(State)		
24. FUNERAL DIRECTOR <i>Francis J. Colletti</i>	ADDRESS <i>500 University Blvd W Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR MAY 2 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

• 6 1/2 - 1 XXXIX, V

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05582

05576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
		Jennie	(NMN)	Cooper	April	23	1969	4:50 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		
Female		White		January 14, 1886		83	YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Russia		America				Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Washington Sanitarium		Owner-Hardware and furniture				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Washington D.C.		D.C.		YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	4700 Connecticut avenue		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		Address	
		Isaac	Miller		Rose Sachs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No				Patient's chart		5 hours		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>ATHEROSCLEROTIC CARDIOSCLEROTIC DISEASE</u> 6 months DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>HYPERTENSION</u></p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>July, 1957</u>, to <u>23 April, 1969</u>, that (II) (we) last saw the deceased alive on <u>22 April, 1969</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE		<u>Robert L. Krichmar</u>		DEGREE	ATTENDING PHYS.	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. DATE SIGNED		
				7733 Georgia Avenue NW Washington DC 20012		23 April 1969		
23a. BUR. A. CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR Crematory		23d. LOCATION (City or Town) (County) (State)		
		4/25/69		Adas Israel Cong. Cem.		Wash., D. C.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Bernard Danzansky and Sons				APR 28 1969		Charles Judge		
3501 14th St., N.W., Wash., D.C.								



05577

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space above. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI. DEATH MATED	Month	Day	Year	2b. HOJR	
<i>William W. COPELAND</i>					<input checked="" type="checkbox"/>	4	10	69	145 m	
3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years in months)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR	
<i>m</i>	<i>Negro</i>	<i>5-2-1884</i>	<i>84</i>			<i>4</i>	<i>- 10 -</i>	<i>69</i>	<i>145 m</i>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
		<i>U.S. A.</i>				<i>Montgomery</i>			Md	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>DICKERSON</i>		<i>Bug Woods Rd 3</i>								
13a. USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
<i>Md</i>		<i>Montgomery Dickerson</i>								
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
<i>Daniel Copeland</i>					<i>Mary DORSEY</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
(If yes give war or dates of service)										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbon monoxide intoxication</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>and conflagration burns of 90% of body</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:45 P.M. 4-10 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Deceased in house which caught fire (cause unknown) and died of carbon monoxide intoxication</i>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. IN HOMOGENEOUS TOWNSHIP, CITY, OR TOWN <i>Dickerson Montg. Md.</i>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		<i>Belden R. Belden</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b. DATE SIGNED <i>April 10, 1969</i>		
EXAMINER'S NAME (Type)		<i>BELDEN R. Belden, M.D., Pathologist</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS <i>Montgomery County Hospital, 1000 Rockville Pike, Rockville, Md.</i>					
23a. B.R.A. CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) (County) (State)			
<i>BURIAL</i>		<i>4/13/69</i>		<i>Jerusalem Cemetery, Poolesville, Montg. Md.</i>						
24. FUNERAL DIRECTOR		ADDRESS		25a. READ BY REG STRAR			25b. REGISTRAR'S SIGNATURE			
<i>Robert L. Snowden</i>		<i>Rockville, Md.</i>					<i>Theresa, Judge</i>			
25c. DATE APR 17 1969										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH												Reg. Dist. No. 05578	
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POTOMAC			c. LENGTH OF STAY IN 1b 84 YEARS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POTOMAC			d. STREET ADDRESS 9119 BRADLEY BLVD.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION													
3. NAME OF DECEASED (Type or print)		First FRANK		Middle —	Last COUNSELMAN	4. DATE OF DEATH APRIL 11		Month	Day	Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH OCT 12, 1884		9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GREENSKEEPER			10b KIND OF BUSINESS OR INDUSTRY GOLF CLUB			11. BIRTHPLACE (State or foreign country) BETHESDA MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME WILLIAM G. COUNSELMAN						14. MOTHER'S MAIDEN NAME JULIA A. OFFUTT							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO 598-10-2701		INFORMANT MRS. PAULINE CLARK		Address 5300 WESTBARD BETHESDA.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)													
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from APRIL 10, 1969 to APRIL 11, 1969, that I last saw the deceased alive on APRIL 10, 1969, and that death occurred at 9:00 P.M. from the causes and on the date stated above.												ADDRESS (Street, city or town, state)	DATE SIGNED APRIL 11, 1969
ACTUAL SIGNATURE VINCENT J. DiFRANCESCO M.D. 6601 GREENTREE ROAD BETHESDA, MD.													
PHYSICIAN'S NAME (Type)		22b. DATE THEREOF 4/14/69			22c. NAME OF CEMETERY OR CREMATORIAL Potomac Church Cemetery			22d. LOCATION (City, town, or county) Potomac, Md.			(State)		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial													
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		ADDRESS						24a. RECD BY REGISTRAR APR 15 1969		24b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

05585

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05573

CERTIFICATE OF DEATH

1. DECEASED-NAME: (Type or print)	First <i>Rosie</i>	Middle <i>BELLE</i>	Last <i>COUNSELMAN</i>	2a. DATE OF DEATH Month Year <i>9 29 '69</i>	2b. HOUR 12:28 M
3. SEX <i>F</i>	4. RACE <i>Caucasian</i>	S. DATE OF BIRTH <i>12/28/88</i>	6. AGE (in years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>MONTGOMERY</i>	10. CITY OR TOWN OF DEATH <i>BETHESDA</i>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>GROSVENOR HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institutionalized before admission) STATE <i>M.D.</i>	13b. COUNTY <i>MONT.</i>	13c. CITY OR TOWN <i>BETHESDA</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>919 Bradley Blvd</i>	
14. FATHER'S NAME First <i>Milton Francis Embrey</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Mary Elizabeth Caywood</i>	Middle <i></i>	Last <i></i>
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO <i></i>	17. INFORMANT <i>Pauline C. Clark (Daughter)</i>	Address <i></i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL ARTERIOSCLEROSIS</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 YEARS</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>GENERALIZED ARTERIOSCLEROSIS</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>			3 YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>JULY 1967</i> to <i>APRIL 29, 1969</i> , that (II) (we) last saw the deceased alive on <i>APRIL 29, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Vincent J. DiFrancesco, MD.</i>					
22c. DEGREE <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>April 29, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>VINCENT J. DI FRANCESCO</i>		22e. ADDRESS <i>6601 GREENTREE RD., BETHESDA, MD.</i>			
23a. BURIAL CREMATION, BURIAL (Specify) <i>BURIAL</i>	23b. DATE <i>5/2/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Potomac Church Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Potomac, Maryland</i>		
24. FUNERAL DIRECTOR <i>TYSON WHEELER FUN. HOME</i>	1331 ADDRESS <i>Rockville Rd.</i>	25a. VEC'D BY REGISTRAR <i>MAX</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05586

05580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED NAME (Type or print)	First Charles	Middle Victor	Last Coupard	2a DATE OF DEATH Month April	Day 25	Year 1969	2b HOUR 5 A.M.
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 1/15/85		6. AGE (In years last birthday) 84	7. IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0
7a BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RECRUITER		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 719 MONROE St	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b COUNTY MONTGOMERY	14. FATHER'S NAME First CHARLES	Middle Couparo	Last SAX	15 MOTHER'S MAIDEN NAME First MARY	Middle Thompson	Last ?
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes or No, or unknown No	16b SOCIAL SECURITY NO Charles Coupard - SAX	17 INFORMANT Charles Coupard - SAX	Address ?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0-10		
<p>IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> (b) <i>A S H D</i> DUE TO, OR AS A CONSEQUENCE OF (c)</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) <i>Premature death efflux, cataract</i></p>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 809 Veirs Mill Rd.	City or Town Rockville, Md.	County Montgomery	State MD		
<p>22a I certify that (I) (the hospital) attended the deceased from 19 APR 1969 to 25 APR 1969, that (I) (we) last saw the deceased alive on 24 APR 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.</p>							
22b. SIGNATURE <i>John S. Saia</i>	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4-25-69		
22d. PHYSICIAN'S NAME (Type) John S. Saia	22e. ADDRESS 809 Veirs Mill Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE April 28, 1969	23c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN	23d. LOCATION (City or Town) Rockville	(County) MARYLAND	(State)		
24. FUNERAL DIRECTOR Joseph GAWLER'S SONS 5730 WISCO. AVE. N.W. DC	ADDRESS 2	25a. RECD BY REGISTRAR DATE 2 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05587

CERTIFICATE OF DEATH

05581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First . Alexander	Middle None	Last Cowan	2a. DATE OF DEATH Month April Day 6 Year 1969	2b. HOUR 3:05 P M
3. SEX Male	4 RACE Cauc.	5 DATE OF BIRTH 2/23/15		6 AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Scotland	7b. CIT ZEN OF WHAT COUNTRY? American	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WSAH Montgomery Md.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San & Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Wash. Sub. San. Commission
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE no	13b. COUNTY Mont.	13c. CITY OR TOWN Riverdale	13d. INS. OF CITY L.M.T.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5906 Longfellow St. E.	
14. FATHER'S NAME David	First Middle None	Last Cowan	15. MOTHER'S MAIDEN NAME First Mary	Middle None	Last Thompson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown	16b. SOCIAL SECURITY NO. 212-30-7924	17. INFORMANT Pt's chart WSH - 7600 Carroll Ave.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Colloblastoma (61111) left parietal lobe 6 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 3/3/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Neoplasm	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED At home <input type="checkbox"/> At work <input type="checkbox"/> While <input type="checkbox"/> At work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) this hospital attended the deceased from Feb 31, 1969, to Apr 6, 1969, that (I) (we) last saw the deceased alive on Mar 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (d) d not view the body after death					
22b. SIGNATURE Arthur H. Itosky MD	DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Apr 7, 1969	
22d. PHYSICIAN'S NAME (Type) Arthur H. Itosky MD	22e. ADDRESS 1015 Spring St. SS. 20910.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 9, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor	(County) Pro Geo	(State) Md.
24. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Md.	25a. REC'D BY REG STAR DATE APR 10 1969	25b. REGISTRAR'S SIGNATURE Charles George		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05582

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First HORACE	Middle HENRY	Last CRAIG	2a DATE OF DEATH April Month Day 29 Year 1969	12b HOUR 12:00AM M
3. SEX Male	4. RACE Caucasian	S. DATE OF BIRTH January 4, 1921	6. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington, D.C. USA	7b. CITIZEN OF WHAT COUNTRY? Washington, D.C. USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electronics Inspector	12b. KIND OF BUSINESS OR INDUSTRY Ser Commiss-		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13c CITY OR TOWN Md. County Lexington Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 305 Kearsarge Place		
14. FATHER'S NAME First GUY	Middle F.	Last CRAIG	15. MOTHER'S MAIDEN NAME Lillian	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	Lost (Unknown)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, WWII, Korea	16b. SOCIAL SECURITY NO 140-05-8914	17. INFORMANT Wife. Mrs. Jean E. Craig Address 305 Keasarge Place, Lexington Park, Md.			20653
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1929 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
MEDICAL CERTIFICATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.	21f. LOCATION Street or RFD No	City or Town	County	State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 4, 1969, to April 29, 1969, that <input type="checkbox"/> (we) last saw the deceased alive on April 29, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE William L. Brannon Jr., MD	DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 29 April 69
22d. PHYSICIAN'S NAME NAME (Type) CDR MC USN	22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND				
23a. BURIAL, CREMATION, BURIAL (Specify)	23b. DATE May 2, 1969	23c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cemetery	23d. LOCATION (City or Town) Arlington	(County) Virginia	(State)
24. FUNERAL DIRECTOR MATTINGLY FUNERAL HOME, ADDRESS Leonardtown, Maryland			25a. REC'D BY REGISTRAR DATE MAY 5 1969	25b. REGISTRAR'S SIGNATURE Charles J. Muller	



05589

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Damon	Middle E.	Last CUMMINGS	2a. DATE OF DEATH Month April Day 20 Year 1969	2b. HOUR 1017PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH Apr. 16, 1885		6. AGE (In years last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Minnesota	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2329 Porter St., N. W.		
14. FATHER'S NAME First Charles	Middle Arthur Cummings	15. MOTHER'S MAIDEN NAME First Ada	Middle Florence	Last Earhart	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes _____ No _____ Unknown _____	16b. SOCIAL SECURITY NO. 1906-46	17. INFORMANT Damon E. Cummings, 27 Auburn St., Woburn, Mass.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause _____ lost _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 9:00 A.M.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from Apr. 20, 1969, to Apr. 20, 1969, that (we) last saw the deceased alive on Apr. 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) (re) view the body after death.					
22b. SIGNATURE <u>John H. Hornbaker Jr. M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED 22 April 1969					
22d. PHYSICIAN'S NAME (Type) J. H. HORNBAKER, JR., M.D. 22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/28/69	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery	23d. LOCATION (City or Town) Arlington	(County) Va.	(State)
24. FUNERAL DIRECTOR Jos. Gowler's Sons ADDRESS 5130 Wisconsin Ave., N.W. Washington, D.C.	25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05584

05590

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in **1**, **2**, **3**, **4**, **5**, **6**, **7**, **8**, **9**, **10**, **11**, **12**, **13**, **14**, **15**, **16**, **17**, **18**, **19**, **20**, **21**, **22**, **23**, **24**, **25**, **26**, **27**, **28**, **29**, **30**, **31**, **32**, **33**, **34**, **35**, **36**, **37**, **38**, **39**, **40**, **41**, **42**, **43**, **44**, **45**, **46**, **47**, **48**, **49**, **50**, **51**, **52**, **53**, **54**, **55**, **56**, **57**, **58**, **59**, **60**, **61**, **62**, **63**, **64**, **65**, **66**, **67**, **68**, **69**, **70**, **71**, **72**, **73**, **74**, **75**, **76**, **77**, **78**, **79**, **80**, **81**, **82**, **83**, **84**, **85**, **86**, **87**, **88**, **89**, **90**, **91**, **92**, **93**, **94**, **95**, **96**, **97**, **98**, **99**, **100**, **101**, **102**, **103**, **104**, **105**, **106**, **107**, **108**, **109**, **110**, **111**, **112**, **113**, **114**, **115**, **116**, **117**, **118**, **119**, **120**, **121**, **122**, **123**, **124**, **125**, **126**, **127**, **128**, **129**, **130**, **131**, **132**, **133**, **134**, **135**, **136**, **137**, **138**, **139**, **140**, **141**, **142**, **143**, **144**, **145**, **146**, **147**, **148**, **149**, **150**, **151**, **152**, **153**, **154**, **155**, **156**, **157**, **158**, **159**, **160**, **161**, **162**, **163**, **164**, **165**, **166**, **167**, **168**, **169**, **170**, **171**, **172**, **173**, **174**, **175**, **176**, **177**, **178**, **179**, **180**, **181**, **182**, **183**, **184**, **185**, **186**, **187**, **188**, **189**, **190**, **191**, **192**, **193**, **194**, **195**, **196**, **197**, **198**, **199**, **200**, **201**, **202**, **203**, **204**, **205**, **206**, **207**, **208**, **209**, **210**, **211**, **212**, **213**, **214**, **215**, **216**, **217**, **218**, **219**, **220**, **221**, **222**, **223**, **224**, **225**, **226**, **227**, **228**, **229**, **230**, **231**, **232**, **233**, **234**, **235**, **236**, **237**, **238**, **239**, **240**, **241**, **242**, **243**, **244**, **245**, **246**, **247**, **248**, **249**, **250**, **251**, **252**, **253**, **254**, **255**, **256**, **257**, **258**, **259**, **260**, **261**, **262**, **263**, **264**, **265**, **266**, **267**, **268**, **269**, **270**, **271**, **272**, **273**, **274**, **275**, **276**, **277**, **278**, **279**, **280**, **281**, **282**, **283**, **284**, **285**, **286**, **287**, **288**, **289**, **290**, **291**, **292**, **293**, **294**, **295**, **296**, **297**, **298**, **299**, **300**, **301**, **302**, **303**, **304**, **305**, **306**, **307**, **308**, **309**, **310**, **311**, **312**, **313**, **314**, **315**, **316**, **317**, **318**, **319**, **320**, **321**, **322**, **323**, **324**, **325**, **326**, **327**, **328**, **329**, **330**, **331**, **332**, **333**, **334**, **335**, **336**, **337**, **338**, **339**, **340**, **341**, **342**, **343**, **344**, **345**, **346**, **347**, **348**, **349**, **350**, **351**, **352**, **353**, **354**, **355**, **356**, **357**, **358**, **359**, **360**, **361**, **362**, **363**, **364**, **365**, **366**, **367**, **368**, **369**, **370**, **371**, **372**, **373**, **374**, **375**, **376**, **377**, **378**, **379**, **380**, **381**, **382**, **383**, **384**, **385**, **386**, **387**, **388**, **389**, **390**, **391**, **392**, **393**, **394**, **395**, **396**, **397**, **398**, **399**, **400**, **401**, **402**, **403**, **404**, **405**, **406**, **407**, **408**, **409**, **410**, **411**, **412**, **413**, **414**, **415**, **416**, **417**, **418**, **419**, **420**, **421**, **422**, **423**, **424**, **425**, **426**, **427**, **428**, **429**, **430**, **431**, **432**, **433**, **434**, **435**, **436**, **437**, **438**, **439**, **440**, **441**, **442**, **443**, **444**, **445**, **446**, **447**, **448**, **449**, **450**, **451**, **452**, **453**, **454**, **455**, **456**, **457**, **458**, **459**, **460**, **461**, **462**, **463**, **464**, **465**, **466**, **467**, **468**, **469**, **470**, **471**, **472**, **473**, **474**, **475**, **476**, **477**, **478**, **479**, **480**, **481**, **482**, **483**, **484**, **485**, **486**, **487**, **488**, **489**, **490**, **491**, **492**, **493**, **494**, **495**, **496**, **497**, **498**, **499**, **500**, **501**, **502**, **503**, **504**, **505**, **506**, **507**, **508**, **509**, **510**, **511**, **512**, **513**, **514**, **515**, **516**, **517**, **518**, **519**, **520**, **521**, **522**, **523**, **524**, **525**, **526**, **527**, **528**, **529**, **530**, **531**, **532**, **533**, **534**, **535**, **536**, **537**, **538**, **539**, **540**, **541**, **542**, **543**, **544**, **545**, **546**, **547**, **548**, **549**, **550**, **551**, **552**, **553**, **554**, **555**, **556**, **557**, **558**, **559**, **560**, **561**, **562**, **563**, **564**, **565**, **566**, **567**, **568**, **569**, **570**, **571**, **572**, **573**, **574**, **575**, **576**, **577**, **578**, **579**, **580**, **581**, **582**, **583**, **584**, **585**, **586**, **587**, **588**, **589**, **590**, **591**, **592**, **593**, **594**, **595**, **596**, **597**, **598**, **599**, **600**, **601**, **602**, **603**, **604**, **605**, **606**, **607**, **608**, **609**, **610**, **611**, **612**, **613**, **614**, **615**, **616**, **617**, **618**, **619**, **620**, **621**, **622**, **623**, **624**, **625**, **626**, **627**, **628**, **629**, **630**, **631**, **632**, **633**, **634**, **635**, **636**, **637**, **638**, **639**, **640**, **641**, **642**, **643**, **644**, **645**, **646**, **647**, **648**, **649**, **650**, **651**, **652**, **653**, **654**, **655**, **656**, **657**, **658**, **659**, **660**, **661**, **662**, **663**, **664**, **665**, **666**, **667**, **668**, **669**, **670**, **671**, **672**, **673**, **674**, **675**, **676**, **677**, **678**, **679**, **680**, **681**, **682**, **683**, **684**, **685**, **686**, **687**, **688**, **689**, **690**, **691**, **692**, **693**, **694**, **695**, **696**, **697**, **698**, **699**, **700**, **701**, **702**, **703**, **704**, **705**, **706**, **707**, **708**, **709**, **710**, **711**, **712**, **713**, **714**, **715**, **716**, **717**, **718**, **719**, **720**, **721**, **722**, **723**, **724**, **725**, **726**, **727**, **728**, **729**, **730**, **731**, **732**, **733**, **734**, **735**, **736**, **737**, **738**, **739**, **740**, **741**, **742**, **743**, **744**, **745**, **746**, **747**, **748**, **749**, **750**, **751**, **752**, **753**, **754**, **755**, **756**, **757**, **758**, **759**, **760**, **761**, **762**, **763**, **764**, **765**, **766**, **767**, **768**, **769**, **770**, **771**, **772**, **773**, **774**, **775**, **776**, **777**, **778**, **779**, **780**, **781**, **782**, **783**, **784**, **785**, **786**, **787**, **788**, **789**, **790**, **791**, **792**, **793**, **794**, **795**, **796**, **797**, **798**, **799**, **800**, **801**, **802**, **803**, **804**, **805**, **806**, **807**, **808**, **809**, **810**, **811**, **812**, **813**, **814**, **815**, **816**, **817**, **818**, **819**, **820**, **821**, **822**, **823**, **824**, **825**, **826**, **827**, **828**, **829**, **830**, **831**, **832**, **833**, **834**, **835**, **836**, **837**, **838**, **839**, **840**, **841**, **842**, **843**, **844**, **845**, **846**, **847**, **848**, **849**, **850**, **851**, **852**, **853**, **854**, **855**, **856**, **857**, **858**, **859**, **860**, **861**, **862**, **863**, **864**, **865**, **866**, **867**, **868**, **869**, **870**, **871**, **872**, **873**, **874**, **875**, **876**, **877**, **878**, **879**, **880**, **881**, **882**, **883**, **884**, **885**, **886**, **887**, **888**, **889**, **8810**, **8811**, **8812**, **8813**, **8814**, **8815**, **8816**, **8817**, **8818**, **8819**, **8820**, **8821**, **8822**, **8823**, **8824**, **8825**, **8826**, **8827**, **8828**, **8829**, **8830**, **8831**, **8832**, **8833**, **8834**, **8835**, **8836**, **8837**, **8838**, **8839**, **8840**, **8841**, **8842**, **8843**, **8844**, **8845**, **8846**, **8847**, **8848**, **8849**, **8850**, **8851**, **8852**, **8853**, **8854**, **8855**, **8856**, **8857**, **8858**, **8859**, **8860**, **8861**, **8862**, **8863**, **8864**, **8865**, **8866**, **8867**, **8868**, **8869**, **8870**, **8871**, **8872**, **8873**, **8874**, **8875**, **8876**, **8877**, **8878**, **8879**, **8880**, **8881**, **8882**, **8883**, **8884**, **8885**, **8886**, **8887**, **8888**, **8889**, **88810**, **88811**, **88812**, **88813**, **88814**, **88815**, **88816**, **88817**, **88818**, **88819**, **88820**, **88821**, **88822**, **88823**, **88824**, **88825**, **88826**, **88827**, **88828**, **88829**, **88830**, **88831**, **88832**, **88833**, **88834**, **88835**, **88836**, **88837**, **88838**, **88839**, **88840**, **88841**, **88842**, **88843**, **88844**, **88845**, **88846**, **88847**, **88848**, **88849**, **88850**, **88851**, **88852**, **88853**, **88854**, **88855**, **88856**, **88857**, **88858**, **88859**, **88860**, **88861**, **88862**, **88863**, **88864**, **88865**, **88866**, **88867**, **88868**, **88869**, **88870**, **88871**, **88872**, **88873**, **88874**, **88875**, **88876**, **88877**, **88878**, **88879**, **88880**, **88881**, **88882**, **88883**, **88884**, **88885**, **88886**, **88887**, **88888**, **88889**, **888810**, **888811**, **888812**, **888813**, **888814**, **888815**, **888816**, **888817**, **888818**, **888819**, **888820**, **888821**, **888822**, **888823**, **888824**, **888825**, **888826**, **888827**, **888828**, **888829**, **888830**, **888831**, **888832**, **888833**, **888834**, **888835**, **888836**, **888837**, **888838**, **888839**, **888840**, **888841**, **888842**, **888843**, **888844**, **888845**, **888846**, **888847**, **888848**, **888849**, **888850**, **888851**, **888852**, **888853**, **888854**, **888855**, **888856**, **888857**, **888858**, **888859**, **888860**, **888861**, **888862**, **888863**, **888864**, **888865**, **888866**, **888867**, **888868**, **888869**, **888870**, **888871**, **888872**, **888873**, **888874**, **888875**, **888876**, **888877**, **888878**, **888879**, **888880**, **888881**, **888882**, **888883**, **888884**, **888885**, **888886**, **888887**, **888888**, **888889**, **8888810**, **8888811**, **8888812**, **8888813**, **8888814**, **8888815**, **8888816**, **8888817**, **8888818**, **8888819**, **8888820**, **8888821**, **8888822**, **8888823**, **8888824**, **8888825**, **8888826**, **8888827**, **8888828**, **8888829**, **8888830**, **8888831**, **8888832**, **8888833**, **8888834**, **8888835**, **8888836**, **8888837**, **8888838**, **8888839**, **8888840**, **8888841**, **8888842**, **8888843**, **8888844**, **8888845**, **8888846**, **8888847**, **8888848**, **8888849**, **8888850**, **8888851**, **8888852**, **8888853**, **8888854**, **8888855**, **8888856**, **8888857**, **8888858**, **8888859**, **8888860**, **8888861**, **8888862**, **8888863**, **8888864**, **8888865**, **8888866**, **8888867**, **8888868**, **8888869**, **8888870**, **8888871**, **8888872**, **8888873**, **8888874**, **8888875**, **8888876**, **8888877**, **8888878**, **8888879**, **8888880**, **8888881**, **8888882**, **8888883**, **8888884**, **8888885**, **8888886**, **8888887**, **8888888**, **8888889**, **88888810**, **88888811**, **88888812**, **88888813**, **88888814**, **88888815**, **88888816**, **88888817**, **88888818**, **88888819**, **88888820**, **88888821**, **88888822**, **88888823**, **88888824**, **88888825**, **88888826**, **88888827**, **88888828**, **88888829**, **88888830**, **88888831**, **88888832**, **88888833**, **88888834**, **88888835**, **88888836**, **88888837**, **88888838**, **88888839**, **88888840**, **88888841**, **88888842**, **88888843**, **88888844**, **88888845**, **88888846**, **88888847**,



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05591

05585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. In any event, within 72 hours of death, this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	Last			2a. DATE OF DEATH Month Day Year	2b. HOUR 12 P.M.
<i>Day</i>	Middle	First	Last	4 30 69	
3. SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>9-15-83</i>	6. AGE (In years at birthday) <i>85</i>	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARR ED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>MONTGOMERY</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		
13a. JESJAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>MONT. GAY CHASE</i>	13c. CITY OR TOWN <i>MONT. GAY CHASE</i>	13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>3504 Turner Lane</i>	
14. FATHER'S NAME First <i>John</i>	Middle <i>Kidwell</i>	Last <i>Mary</i>	15. MOTHER'S MAIDEN NAME First <i>Ziegeneck Soper</i>	Middle <i>3512</i>	Last <i>Turner Lane, Ch. Md.</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>217-52-7220</i>	17. INFORMANT <i>Les Day</i>	Address <i>3512 Turner Lane, Ch. Md.</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>17 days</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gastro Intestinal Hemorrhage</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Myocardial Ischemia & congestive Heart Failure</i>					
19a. DATE OF OPERATION <i>4/14/69</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Emergency</i>	20a. AUTOPSY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>At home</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <i>At home</i>	21f. LOCATION Street or R.F.D. No <i>3504</i>	City or Town <i>Bethesda</i>	County <i>Md.</i>	State <i>Md.</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>4/14/69</i> , to <i>4/20/69</i> , that (I) (we) last saw the deceased alive on <i>4/13/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A. J. BRENNAN MD</i>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4/20/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>A. J. BRENNAN</i>	22e. ADDRESS <i>Bethesda, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>5-3-69</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville Mont Md</i>		
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>	25a. ADDRESS <i>7557 Wisconsin Ave</i>	25b. REC'D BY REGISTRAR DATE <i>MAY 7 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Wanda, Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

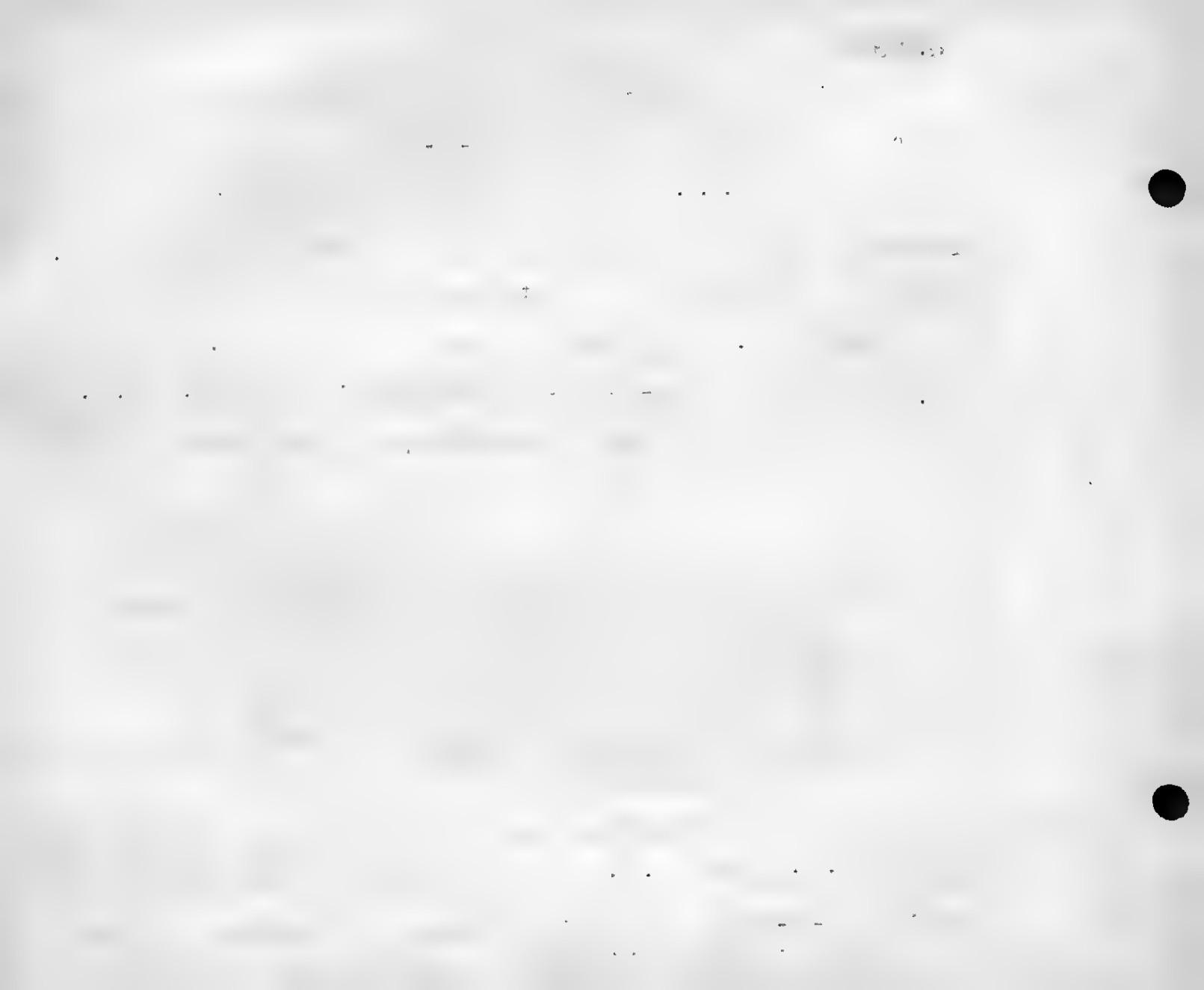
05592

05586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If any event, within 72 hours and 30 minutes, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED-NAME (Type or print)	First Mattie	Middle Rebecca	Last Day	2a. DATE OF DEATH April March 20, 1969	2b. HOUR 5 PM				
3. SEX Female	4. RACE White	5. DATE OF BIRTH 10-23-1890		6. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS 6	IF UNDER 24 HRS. DAYS 0	IF UNDER 12 HRS. HOURS 0	IF UNDER 6 HRS. MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Gaithersburg		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY No.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER -					
14 FATHER'S NAME First Hanry	Middle D.	Last Measell	15 MOTHER'S MAIDEN NAME First Susan	Middle R. Staley	Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECUR TY NO. 577-42-8907-J1	17 INFORMANT Mamie Heffner	Address 6012 Milfan Dr S. E. 20027						
18 CAUSE OF DEATH (Enter only one cause per line 18 (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diarrheal enteritis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks			
(b) Diarrheal enteritis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)						10 yrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED <input type="checkbox"/> At home <input type="checkbox"/> Not while at work <input type="checkbox"/> at work	21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from 11/1/68 , 19 68 , to 11/1/69 , 19 69 , that (I) (we) last saw the deceased alive on 11/15/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George C. Scruggs, M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/20/69					
22d. PHYSICIAN'S NAME (Type) H. C. Scruggs, M. D.	22e. ADDRESS 5413 Cedar Lane Bethesda MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-23-1969	23c. NAME OF CEMETERY OR CREMATORIAL Forestville Methodist	23d. LOCATION (City or Town) Forestville	(County) Maryland	(State)				
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland			25a. REC'D BY REGISTRAR APR 24 1969	25b. REGISTRAR'S SIGNATURE William J. George					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05593

CERTIFICATE OF DEATH

05587

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, staple and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Robert	Middle Francis	Last Dearduff	2a. DATE OF DEATH Month April	2b. HOUR A.M. 12:00
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 28, 1908		6. AGE (In years last birthday) 60	1e UNDER 1 YEAR MONTHS 0	1e UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) New York	7b. CITIZEN OF WHAT COUNTRY? America	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager-kohb Electric Co.	
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7125 Carroll Avenue		
14. FATHER'S NAME First Frank	Middle S.	Last Dearduff	15. MOTHER'S MAIDEN NAME First Teresa	Middle Barron	Last	
16a. WAS DECASSED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218 03 5570	17. INFORMANT Patient's chart	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Anterior Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 4109 Artherosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 day yes		
DUE TO, OR AS A CONSEQUENCE OF (b) Artherosclerosis BUE TO, OR AS A CONSEQUENCE OF (c) An episode AV block + RBBB						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from APR. 19 , 1969, to APR. 22 , 1969, that (I) (we) last saw the deceased alive on APRIL 21 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Charles H. Wolofson	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-22-69	
22d. PHYSICIAN'S NAME (Type) CHARLES H. WOLOFSON	22e. ADDRESS 831 University Blvd. E., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated	23b. DATE April 24 1969	23c. NAME OF CEMETERY OR CREMATORIAL First Rosedale Cemetery	23d. LOCATION (City or Town) Calmont Manor Cr Lee Mall	County Calverton	(State) Md.	
24. FUNERAL DIRECTOR Arthur Walter	ADDRESS By DAY 234 Carroll St. Atw. Wash. 12, D.C.	25a. REC'D BY REGISTRAR APR 24 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05594

05589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Mrs Lottie</i>	Middle <i>Delahanty</i>	Last <i></i>	2a. DATE OF DEATH Month <i>4</i>	Day <i>17</i>	Year <i>69</i>	2b. HOUR <i>9:30 P.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4-9-91</i>			6. AGE (In years last birthday) YRS. <i>78</i>	IF UNDER 1 YEAR MONTHS <i></i>	F UNDER 24 MRS. HOURS <i></i>
7a BIRTHPLACE (State or foreign country) <i>Chancery N.J.</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>			Md	
10 CITY OR TOWN OF DEATH <i>Wheaton</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>			12a USUAL OCCUPATION (kind of work done during most of working life, even if retired) <i>Prison Matron</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Trenton N.J.</i>
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Trenton N.J.</i>	13b COUNTY <i>MERCER</i>	13c CITY OR TOWN <i></i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i></i>			
14 FATHER'S NAME First <i>xxxxxx</i>	Middle <i>James L. Courtney</i>	Last <i></i>	15 MOTHER'S MAIDEN NAME First <i>xxxxxx</i>	Middle <i>Mary A. Haggerty</i>	Last <i></i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b SOCIAL SECURITY NO <i>138-30-8469</i>	17. INFORMANT <i>Mr James M. Delahanty Wash DC</i>	Address <i>3717-29th St SE</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>Multiple myeloma.</i>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State	
22a I certify that (I) (this hospital) attended the deceased from <i>1/14</i> , 19 <i>69</i> , to <i>4/17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/17</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Myron L. Lenkin</i>		MR DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c DATE SIGNED <i>4/17/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Myron L. Lenkin</i>		22e. ADDRESS					
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>April 21, 1969</i>	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>St. John's Cemetery 8434 Georgia Avenue</i>	23d LOCATION (City or Town) <i>Trenton, New Jersey</i>	(County)	(State)	
24. FUNERAL DIRECTOR <i>Paul E. Smith & Son, Inc.</i>		25a. REG'D BY REGISTRAR DATE <i>APR 22 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05595

05595

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be signed by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Thomas</i>	Middle <i>V.</i>	Last <i>Delaney</i>	2a DATE OF DEATH Month <i>4</i>	Day <i>6</i>	Year <i>1969</i>	2b. HOUR <i>5:52 P.M.</i>	
3 SEX <i>Male</i>		4. RACE <i>White</i>		S. DATE OF BIRTH <i>7-1-05</i>	6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	2b. HOUR HOURS <i>552</i>
7a BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburbans</i>		12a. US.JA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>722 Somerset Place N.W.</i>		
14 FATHER'S NAME First <i>John</i>		Middle <i>A</i>	Last <i>Delaney</i>	15 MOTHER'S MAIDEN NAME First Middle <i>MARY A. Augier</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO <i>578-01-5611</i>		17 INFORMANT <i>MARY E. Tutt - 3630 13th St N.E.</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subdural hemorrhage, spontaneous</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 hours</i>			
<i>4304</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured berry aneurysm, left middle cerebral artery</i>				<i>10 hours</i>			
		(c) <i>Cerebral arteriosclerosis</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Subacute and chronic pancreatitis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1952</i> , to <i>4-6</i> , <i>1969</i> , that (I) (we) last saw the deceased alive on <i>4-6</i> <i>1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Sarah E. Glover, M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4-7-69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Sarah E. Glover, M.D.</i>		22e. ADDRESS <i>10128 Cedar Lane, Kensington, Md.</i>							
23a BUR.A., CREMATON, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>4-10-69</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>		23d LOCATION (City or Town) <i>Washington, D.C.</i>	(County) <i>D.C.</i>	(State)		
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>		ADDRESS <i>1100 University Blvd. in Seattle</i>	25a. RECEIVED BY REGISTRAR DATE <i>APR 15 1969</i>		25b. APPROVING S. SIGNATURE <i>Francis J. Collins</i>				

4

7

8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05591

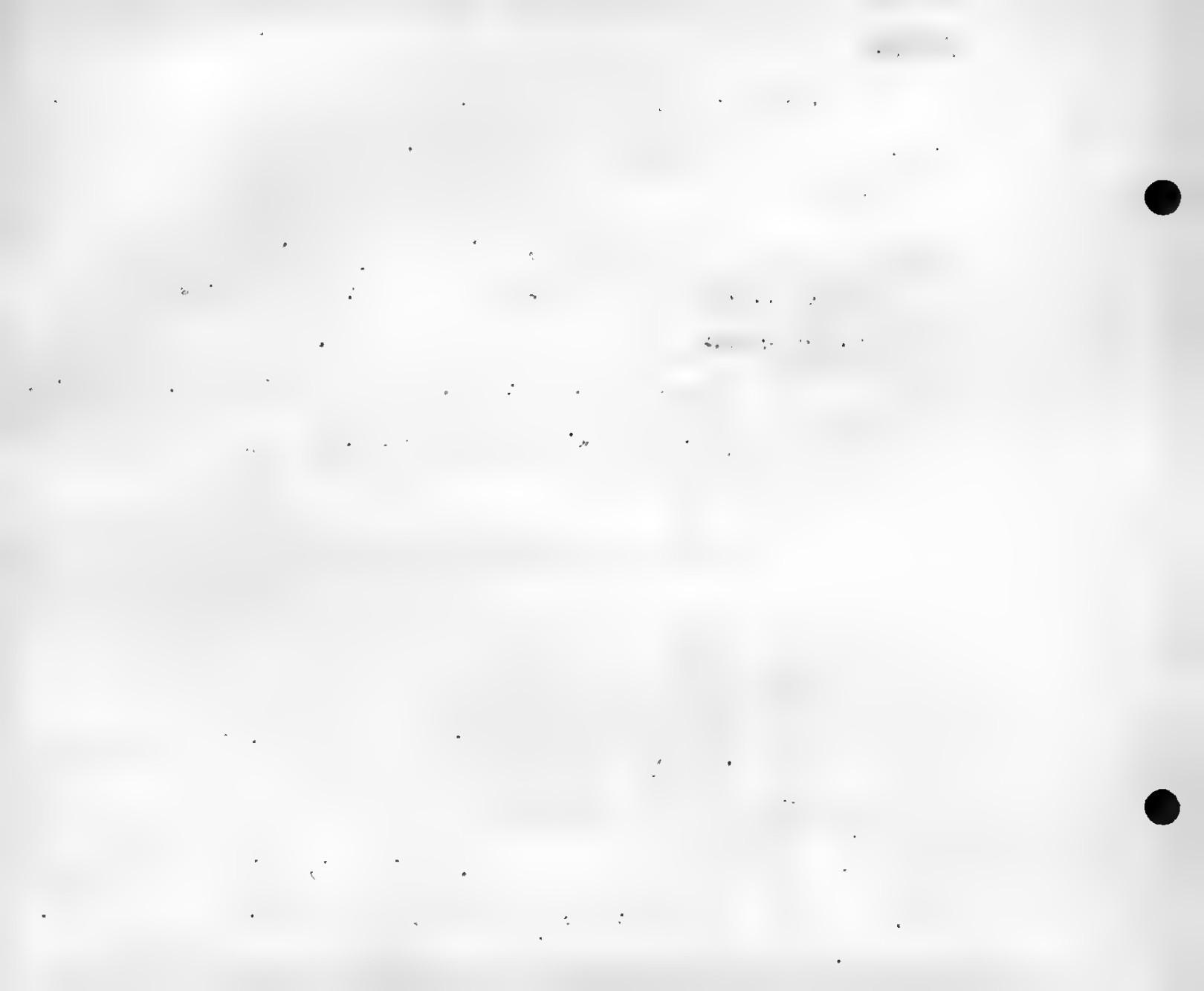
05596

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. If you do not have carbon paper, then please remove the first page and file with the State Dept. of Health prior to burial, cremation, or removal, and retain event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month APRIL Day 18 Year 69		2b. HOURA 6:09 M
JOSEPHINE KLOBER				DELAPA			
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH 28 JUNE 1921		6. AGE (In years last birthday) 47 yrs.	
7a. BIRTHPLACE (State or foreign country) NEW Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETH MD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Md	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4010 ADAMS DRIVE	
14. FATHER'S NAME First CHARLES KLOBER		Middle	Last	15. MOTHER'S MAIDEN NAME First Minna		Middle	Last Ruland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO. 154-14-8134		17. INFORMANT FIORE S. DELAPA		Address 4010 ADAMS DR. WHEATON MD.	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY,</p> <p>IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASIS</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1538</p> <p>(b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>							
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)</p>							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (X) (this hospital) attended the deceased from 11 APRIL, 1969 , to 18 APRIL, 1969 that (X) (we) last saw the deceased alive on 18 APRIL, 1969 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.							
22b. SIGNATURE JR Fletcher M.D.		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 18 APRIL 1969	
22d. PHYSICIAN'S NAME (Type) JOHN R. FLETCHER MD		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-21-69	23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT CEMETARY		23d. LOCATION (City or Town) ARLINGTON		(County) VA.
24. FUNERAL DIRECTOR Collins		ADDRESS SILVER SPRING MD			25a. REC'D BY REGISTRAR APR 23 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	
COLLINS FUNERAL HOME 500 UNIVERSITY BLVD							



Cleared with Medical Examiner/As

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 19
05597

05592

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	2b. HOUR Year
CHARLES RAYMOND DENNIS				April	17, 1969
3. SEX Male	4 RACE White	S. DATE OF BIRTH August 31, 1903	6. AGE (In years lost birthday) 65	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) wash. San. & Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of work or life, even if ret red) Telephone Company	12b. KIND OF BUSINESS OR INDUSTRY C & P Tel Co		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13c. CITY OR TOWN Takoma Pk.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1116 Jackson Ave Takoma Park, Maryland		
14. FATHER'S NAME Charles Dennis	15. MOTHER'S MAIDEN NAME Cleora Shockley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown None	16b. SOCIAL SECURITY NO. 577-01-0051	17. INFORMANT Mrs. Gertrue Dennis ---- Wife	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 410.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 25 1968</i> , to <i>Aug 17, 1969</i> , that (I) (we) last saw the deceased alive on <i>Aug 19, 1969</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Boris Rabkin, M.D.</i>					
22d. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>April 18, 1969</i>
23a. BURIAL OR CREMATION		23b. DATE <i>Apr. 21, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cemetery</i>	23d. LOCATION (City or Town) <i>Bladensburg, Maryland</i>	(County) (State)
24. FUNERAL DIRECTOR'S ADDRESS <i>Glen Carter, Inc., 18434 Georgia Avenue, Silver Spring, Md.</i>		25a. REGISTRY REGISTRAR <i>Warren E. Pumphrey, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	
45M - 1		DATE <i>APR 22 1969</i>		DATE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												MEDICAL EXAMINER'S CERTIFICATE OF DEATH				05598			
1. DECEASED NAME (Type or Print)			First KATHLEEN			Middle MACNEAL			Last DENT			2a DATE KNOWN OF EST. DEATH		Month 4	Day 11	Year 1969	2b HOUR 655 P.M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 7/4/66		6 AGE (in years 2 nd birthday) 2 yrs		7 IF JUNIOR 1 YEAR MONTHS DAYS		8. MARRIED WIDOWED		9. COUNTY OF DEATH Montgomery		2c. DATE PRONOUNCED DEAD Month 4 Day 11 Year 1969		2d. HOUR 655 P.M.			
7a BIRTHPLACE (State or foreign country) Wash., D.C.			7b CITIZEN OF WHAT COUNTRY? U. S.																
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b KIND OF BUSINESS OR INDUSTRY None										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE I.d.			13c. CITY OR TOWN Prince Geo. Beltsville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 13024 Ingleside Drive										
14 FATHER'S NAME Theodore H.			15. MOTHER'S MAIDEN NAME Dent, Jr.			16. SOCIAL SECURITY NO. None			17. INFORMANT Theodore Dent, Sr., Chevy Chase, Maryland			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			Multiple Extreme Injuries									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) including Fractured Skull.																
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year P.M. 4-11 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 21) Crash released brake, fell out of auto and was run over			21f. LOCAT.ON Street or R.F.D. No. 13024 Ingleside Dr. City or Town Beltsville County Prince George State Md			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Street																
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE BELDEN R. REAP M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED April 11, 1969										
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/15/69			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d. LOCATION (City or Town) Silver Spring, Maryland			(County) (State)							
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Washington, D.C. 20016			5130 Wisconsin Ave., N.W.						25a. REC'D BY REGISTRAR APR 15 1969			25b. REGISTRAR'S SIGNATURE Charles Judge							

2.5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05594

1. DECEASED NAME (Type or Print)			First ERWIN	Middle C	Last DIETLE	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/>	Month 4	Day 30	Year 169	2b. HOUR 7:09	
3 SEX Male	4 RACE White	5. DATE OF BIRTH 11/5/17	6. AGE (in years last birthday) 51 YRS	IF UNDER 1 YEAR MONTHS 0	DAYS 0	IF UNDER 24 HRS HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month 4 Day 30 Year 1969			
7a. BIRTHPLACE (State or foreign country) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Dept. Sto		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIM.TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 10012 Portland Rd. S. Md			
14. FATHER'S NAME First Richard Middle J Last Dietle			15. MOTHER'S MAIDEN NAME First Patilda Middle (unknown) Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) yes			17. INFORMANT wife Ruth 10012 Portland Rd. S. Md			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line 18(a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Coronary Artery Heart Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20. AUTOPSY?
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											22b. DATE SIGNED 4/30/1969
ACTUAL SIGNATURE Belden R. Roop M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BELDEN R. ROOP M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, City, Town and County)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE May 2, 1969			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION (City or Town) (County) (State) Rockville Maryland		
24. FUNERAL DIRECTOR (Name and Address) Warren E. Pumphrey, 910. 8434-Ga. Ave. Silver Spring, Maryland						25a. REC'D BY REGISTRAR DATE MAY 5 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

$\Omega_{\tau} \sim \mathcal{O}_2$

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05595

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Year 9:22 PM
FRANK ELLSWORTH DIETZ			4	17	1969
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) 74 YRS.		
MALE	CAUCASION	1/9/1895	IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
WASH. D.C.	USA				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED	
KENSINGTON	KENSINGTON GAR. SANT.			12b. KIND OF BUSINESS OR INDUSTRY	
13c. JS/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD.	MONT.	BETH.		5906 WALTON ROAD	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First
John	P		DIETZ	CLARA	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO (If yes give war or dates of service) W.W.I	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Thrombophlebitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerosis + Diabetes</u>		
	-	ANNIE B. DIETZ	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks. TOA. 1969		
Address 5906 WALTON RD. BETHESDA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 1962, to Apr 17, 1968, that (I) (we) last saw the deceased alive on Aug 12 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE James E Nolan MD		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-17-69
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 5401 Western Ave NW.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-1969	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d. LOCATION (City or Town) Rockville, Montgomery Co., Md.	(County) (State)
24. FUNERAL DIRECTOR		ADDRESS 5130 WISG. AVE. N. W. WASH. D. C. 20016		25a. REC'D BY REGISTRAR APR 23 1969	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

any delay is
1. my delay is
2. and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Bureau Page 5 may be retained for your files.

File pages 1 and 2 with the State Department of

05601

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05596

1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN <input checked="" type="checkbox"/> ESTIMATE DEATH MATED <input type="checkbox"/>	Month	Day	Year	2b. HOUR	
Annie		M.	Dimmie		4	25	1969	9	PM	
3. SEX	4 RACE	S. DATE OF BIRTH	6. AGE (in years at time of death) 79	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 4 Day 25 Year 1969				2d. HOUR	
Fe	Negro	1-26-1890	YRS.							
7a. BIRTHPLACE (State or Foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Norbeck		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 15720 Bradford Rd.)		12a. USUAL OCCUPATION (Kind of work done during month of death, if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. CITY OR TOWN Montg.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 15720 Bradford Rd.				
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Kissie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Helen Hatton (daughter)			ADDRESS same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194X <i>Carcinoma of Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. with metastasis. (b) <i>due to, or as a consequence of</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>due to, or as a consequence of</i> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED May 2, 1969
ACTUAL SIGNATURE <i>Belden R. Neafpe</i>		EXAMINER'S NAME (Type) <i>BELDEN R. NEAFPE MD</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADVISORY MEDICAL EXAMINER (if applicable)						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-3-69		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SHILOH BAPTIST CEM. ROCKVILLE, MD			23d. LOCATION (City or Town) (County) (State) PALMYRA FLUVIANNA VA.			
24. FUNERAL DIRECTOR ROBERT L. SNOWDEN				25a. REC'D BY REGISTRAR MAY 5 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Juge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0559

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in my presence, I bind 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. [Page 3] bind 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 8A M	
JOHN				Raymond DONALDSON, Jr.	APRIL 2	1969			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/18/100		6. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Trans-it Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE WEST VA		13b. COUNTY Jefferson		13c. CITY OR TOWN SHEPARDSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER MAIN ST	
14. FATHER'S NAME JAMES		15. MOTHER'S MAIDEN NAME First DONALDSON		EMMIA		Middle		Last COLLINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown No		16b. SOCIAL SECURITY NO. *****		17. INFORMANT Wife		Address Same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Bronchogenic carcinoma							
DUE TO, OR AS A CONSEQUENCE OF (b)									
Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause (c)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Say</u> , 19 <u>59</u> , to <u>2 Apr</u> , 19 <u>69</u> , that (D) (we) last saw the deceased alive on <u>1 Apr</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John W. Wynn</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 21 Apr 69	
22d. PHYSICIAN'S NAME (Type) John W. Wynn		22e. ADDRESS 7801 Montebello Ave. Bethesda MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-69		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		23d. LOCATION (City or Town) Bethesda, Montg. Co. Md.		(County) (State)	
24. FUNERAL DIRECTOR Robert A. Kempsey		ADDRESS 7552 - 1/2 acre		25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05603

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05598

1. DECEASED-NAME (Type or Print)	First <i>Jo - Ann</i>	Middle <i>Joyce</i>	Last	2a DATE KNOWN OR ESTI- MATED <input checked="" type="checkbox"/>	Month <i>April</i>	Day <i>30</i>	Year <i>1969</i>	2b HOURS <i>10:30 AM</i>			
3 SEX <i>female colored</i>	4. RACE <i>American</i>	5 DATE OF BIRTH <i>2/23/43</i>	6 AGE (in years at birthday) <i>26 yrs</i>	7 IF UNDER 1 YEAR MONTHS <i>0</i>	8 IF UNDER 24 HRS DAYS <i>0</i>	9 HOURS <i>0</i>	10 MIN <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>April</i>	Day <i>30</i>	Year <i>1969</i>	2d HOUR <i>10:30 AM</i>
10a BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	11b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>School teacher</i>						12b KIND OF BUSINESS OR INDUSTRY <i>Montgomery</i>	
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Reside before admission) STATE <i>MD</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Tuberculosis Hospital</i>	13d. INSIDE CITY LIMITS <i>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>	13e. STREET AND NUMBER <i>Clifford Rd-Rt. 2</i>							
14. FATHER'S NAME First <i>William</i>	Middle <i>Battle</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Frank Walker</i>	Middle	Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>No</i>	17. INFORMANT <i>Frank Walker</i>	ADDRESS <i>Horseshoe Bobbin</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1-2 days</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Mitral Stenosis</i> - <i>years</i> (c) <i>Rheumatic Heart Disease</i> - <i>years</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>While at Work</i>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>May 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Lincoln Park</i>		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John B. Bell</i>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>May 6, 1969</i>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Rockville, Md</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-6-69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln Park</i>				23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md</i>			
24. FUNERAL DIRECTOR <i>Robert L. Swanson</i>		ADDRESS <i>Rockville, Md</i>		25a. REC'D BY REGISTRAR <i>MAY 5 1969</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0559

05604

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Year			
				Donald	William	Doss	April 23, 1969	2:45 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UND.R MONTHS	YEAR DAYS	IF UND.R 24 HRS HOURS	M.N.
Male		White		May 12, 1890		78 yrs.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Iowa		America				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Sanitarium				Painter--Carpenter					
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER					
Maryland		Montgomery		Rockville		5807 Worcester Avenue					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
		Dan		Doss			Alice		Rea		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		217-0903523-4 Patient's chart									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), between onset and death <u>4270</u> Months											
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Bronchitis</u>											
19a. MEDICAL CERTIFICATE ON		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from January 1969, to April 23, 1969, that (I) (we) last saw the deceased alive on April 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stuart L. Nelson</u>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED 4-23-69			
22d. PHYSICIAN'S NAME (Type) STUART L. NELSON		22e. ADDRESS ROCKVILLE, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/25/69		23c. NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH CEMETERY		23d. LOCATION (City or Town) WESTMINSTER, MD.		(County)		(State)	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		ADDRESS		25a. REC'D. BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE Charles J. Myers					
VR A15 45M											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

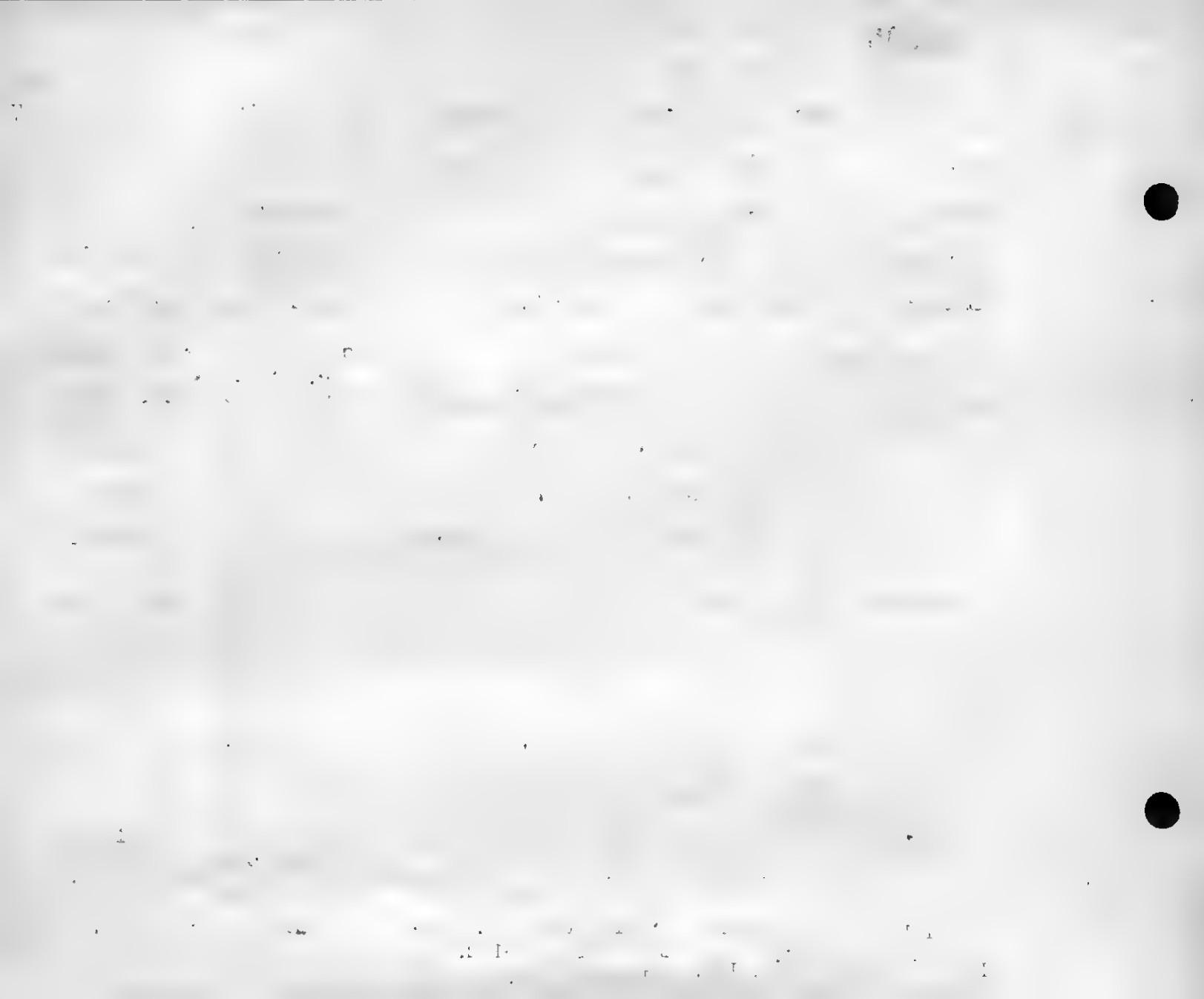
05600

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR	
Jesse Carl Downing						April	27		1969	11:57	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		17 April 1919		50		MONTHS	DAYS	HOURS	MIN
7e. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Washington DC		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
Bethesda		The Clinical Center, NIH				Press Secretary					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res-dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Virginia		Arlington		Arlington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6112 North 22nd Road			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Jesse				Downing	Mamie				Bruce		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Bethesda, Md. 20014 Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No				Not Available		The Medical Records, The Clinical Center		Minutes			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pneumonia (Bilateral) DUE TO, OR AS A CONSEQUENCE OF lost (c) Jakob Creutzfeldt Disease											
DAYS											
MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (we) attended the deceased from 10 April, 1969, to 27 April, 1969, that (we) last saw the deceased alive on 27 April, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) did not view the body after death.											
22b. SIGNATURE		Howard H. Kaufman MD		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		Howard H. Kaufman, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4-30-1969		National Memo. Park		Falls Church		Va.			
24. FUNERAL DIRECTOR		2847 Wilson Blvd.		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles E. Bangs Ives Funeral Home, Inc.		Arlington, Va.		MAY 1 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL UK ATTENDING PHYSICIAN: The law requires that

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
KITTIEBEL			C.		DURLAND	Month	4	Day	7	Year	1969	
3. SEX			4 RACE	WHITE	S. DATE OF BIRTH	9/12/77			IF UNDER 1 YEAR MONTHS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			IF UNDER 24 HRS MONTHS		
New York			USA				Montgomery County			DAYS		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville			19010, Md. Inf. & Eye Home			Housewife						
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER						
New York				Elmira		616 W. 1st. Street						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
William Porter Chapman						Elizabeth Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			3900 Watson Place, N.W. Mrs Larned Blatchford Washington, D.C.			
no			071-09-9698									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4339</u> <u>Cerebral Defecation</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral Thrombosis</u> <u>24 hrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Central Arteriosclerosis</u> <u>Indirect</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>												
19a. DATE OF OPERAT. ON		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/67</u> , 1967, to <u>4/7/69</u> , 1969, that (I) (we) last saw the deceased alive on <u>9/2/67</u> , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Stephen N. Jones</u>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>4/7/69</u>						
22d. PHYSICIAN'S NAME (Type) Stephen N. Jones			22e. ADDRESS Rockville, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4/7/69		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION (City or Town) Prince George Co., Md.		(County)		(State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		ADDRESS			25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
VR A5 45M - 4269												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05607

05602

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Harry	Middle Leonard	Last Easton	2a. DATE OF DEATH April Month 12 Day 69 Year 6 a.m.	2b. HOUR			
3. SEX Male	4 RACE White	5. DATE OF BIRTH Aug. 17th 1903		6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Sandy Spring	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 802, Sandy Spring Rd				
14. FATHER'S NAME First Harry	Middle Shield	Last Easton	15. MOTHER'S MAIDEN NAME First Carrie	Middle S	Lost Disney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 216-10-6509	17. INFORMANT Mrs. Harry L. Easton	Address Same as 13		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
<p>IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 4/10/69 , to 4/12/69 , that (I) (we) last saw the deceased alive on 4/10/69 , and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) (had) (not) view the body after death.								
22b. SIGNATURE <i>C.H. Ligon</i>	DEGREE ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4/12/69				
22d. PHYSICIAN'S NAME (Type) Dr. C.H. Ligon	22e. ADDRESS Sandy Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 15, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Friends	23d. LOCATION (City or Town) Sandy Spring Mont. Md.	(County)	(State)			
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Laytonsville, Md.	25a. REC'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A1 30M REV. <i>1968</i>								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05608

05603

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First <i>Mary</i>	Middle <i>S. Emmert</i>	Last <i>Emmert</i>	2a DATE OF DEATH Month Day Year <i>4 4 69</i>	2b HOUR <i>9 A.M.</i>
3 SEX <i>Female</i>		RACE <i>White</i>	5. DATE OF BIRTH <i>9-30-84</i>		6. AGE (In years day/birthday) <i>84</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>		12b KIND OF BUSINESS OR INDUSTRY <i>None</i>
13a USJAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Gainesville</i>	13d HS/DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>15 Decellum Avenue</i>	
14 FATHER'S NAME First <i>F. S. S.</i>		Middle <i>A.</i>	Last <i>Emmert</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>A.</i>	Last <i>Saffer</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-44-2016</i>		17. INFORMANT <i>Laura H. Clagett - Cousin</i>		
				Address <i>11 S. Summit Ave Gaithersburg, Md.</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>497</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause <i>last.</i>		DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1961</i> , to <i>Apr. 4, 1969</i> , that (I) (we) last saw the deceased alive on <i>4/3 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>L. L. Lewis</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>L. L. Lewis</i>		22e. ADDRESS <i>Gaithersburg, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>4/7/69</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill</i>		23d LOCATION (City or Town) <i>Hagerstown</i>	(County) <i>Washington</i>
24. FUNERAL DIRECTOR <i>V.C. Neth Barnesville Md.</i>		ADDRESS	25a. PAGED BY REGISTRAR DATE <i>APR 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia J. George</i>	(State) <i>Md.</i>

271.1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05609

CERTIFICATE OF DEATH

05604

Cleared with Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print) William George Evans III			2a. DATE OF DEATH Month 4 Day 9 Year 69	2b. HOUR A 12:55
3 SEX Male	4 RACE White	S. DATE OF BIRTH 6/12/34	6. AGE (in years last birthday) 34 YRS.	F UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) W.Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Systems Analyst	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12845 Holiday Lane
14. FATHER'S NAME First William Middle George Last Evans Jr.	15. MOTHER'S MAIDEN NAME First Marguerite Middle Garlach			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) yes 1957-59	16b. SOCIAL SECURITY NO. ?	17. INFORMANT Sylvia Evans	Address 12845 Holiday La Bowie Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes				
569.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (was) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.				
22b. SIGNATURE <i>G. Lennard Gold</i>		DEGREE Attending Phys.	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/9/69
22d. PHYSICIAN'S NAME (Type) G. Lennard Gold		22e. ADDRESS 9801 Ga. Ave. Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Private Burial	23b. DATE April 14, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Woodmere Cemetery	23d. LOCATION (City or Town) Huntington, West Virginia	(County) (State)
24. FUNERAL DIRECTOR Glen Carter	ADDRESS 18434 Georgia Avenue	25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE <i>Glen Carter</i>
Warren E. Purphrey, Inc. Silver Spring, Md.				

201
0.0 1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0

202
0.0 1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE
HEALTH DEPT.**

05610

05605

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First Georgia	Middle S.	Last Fahey	2a DATE KNOWN <input type="checkbox"/> Month July Day 27 Year 1969	2b HOUR 00						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday) 72 yrs	7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	8c DATE PRONOUNCED DEAD Month April Day 30 Year 1969	2d HOUR 00					
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? Virginia	7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Tu B'nai B'rith Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Businesswoman	12b KIND OF BUSINESS OR INDUSTRY Private			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b COUNTY Montgomery	13c CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 4400 East West Highway	14. FATHER'S NAME First Samuel Middle Kirley Last Fahey	15. MOTHER'S MAIDEN NAME First Rina Middle - Last -	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 222-22-2222	17. INFORMANT William Fahey / Son	ADDRESS (SON) 1500 Rockville Pike	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH udden
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause Hyper tension						(b) Coronary Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF Hyper Tensive Cardio Vascular Disease			years.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. 1500 Rockville Pike			City or Town Rockville	County Montgomery	State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John J. Bell</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED May 6, 1969			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)					
23a BLR AL, CREMAT ON, REMOVAL (Specify) Burial	23b. DATE 5-5-1969	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Md. Suitland, Prince Georges Co.						
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC. 1130 WISCONSIN AVE., N. W. WASH., D. C. 20016	25a. RECD BY REGISTRAR MAY 6 1969			25b. REGISTRAR'S SIGNATURE <i>John J. Bell</i>							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05611

05606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 9:05 AM
3. SEX <input checked="" type="checkbox"/>		4 RACE White	5. DATE OF BIRTH 9/23/03		6. AGE (in years last birthday) 65 yrs.	
7a. BIRTHPLACE (State or foreign country) Tunis.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sibley Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) STATE DC		13b. CITY OR TOWN Wash.	13c. INSIDE CITY, IN TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6200 Marylandland	
14. FATHER'S NAME James Eare Stanger		15. MIDDLE James	16. S. MOTHER'S MAIDEN NAME Elizabeth Bates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 511 24 2850	17. INFORMANT Mary George alone		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4319		Cerebral Hemorrhage				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis				
		DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
Diverticulitis & Carcinoma Sigmoid Colon						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 3-24, 1969, to 4-14, 1969, that (I) (we) last saw the deceased alive on 4-14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE IRA MILLER MD		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4-15-69
22d. PHYSICIAN'S NAME (Type)	IRA MILLER, M.D.		22e. ADDRESS 8218 Wisconsin Ave, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-17-69	23c. NAME OF CEMETERY OR CREMATORIAL Green Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Stephens City, Virginia			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland	755 Wisconsin Ave		25a. REC'D BY REGISTRAR DATE APR 21 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

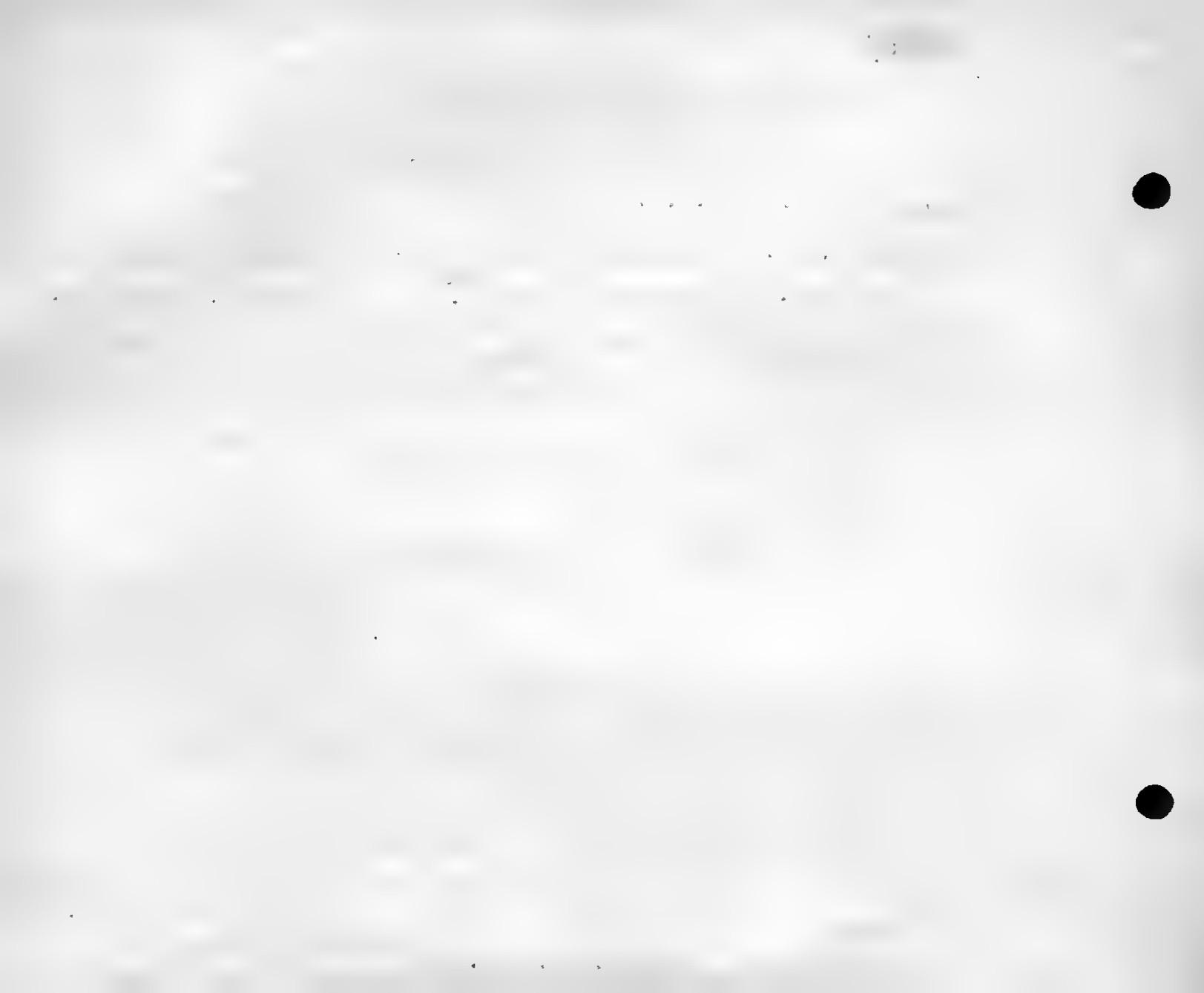
05612

05601

Cleared & medical examiner
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and fill with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>JAMES</i>	Middle <i>S.</i>	Last <i>FRASER</i>	2a. DATE OF DEATH Month <i>4</i>	Day <i>20</i>	Year <i>69</i>	2b. HOUR <i>3:30 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>May 2, 1886</i>		6. AGE (in years last birthday) <i>82</i>		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Kensington, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9611 Hillridge, Drive</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Accountant. Ret. Real estate</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Florida</i>		13b. CITY OR TOWN <i>Broward Deerfield</i>		13d. INSIDE CITY LIMITS? <i>YES <input type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>512-N.E. 21st. Ave.</i>		
14. FATHER'S NAME First <i>Charles</i>		Middle <i>Edward</i>	Last <i>Fraser</i>	15. MOTHER'S MAIDEN NAME First <i>Georgianna</i>		Middle <i>N.M.N.</i>	Last <i>Anderson</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-44-2371-J#1</i>		17. INFORMANT <i>Doris F. Canova</i>		Address <i>9611 Hillridge, Dr. Kensington, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of rectum & metastases</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <i>4-1, 1969</i> , to <i>4-20, 1969</i> , that (I) (we) last saw the deceased alive on <i>4-15, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Jason Berger, M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4-20-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Dr. Jason Berger, M.D.</i>		22e. ADDRESS <i>800 PERSHING DRIVE SILVER SPRING, MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>4/21/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's Crematory</i>		23d. LOCATION (City or Town) <i>Washington, D.C.</i>		(County) (State)
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS <i>300-4th. St. N.E.</i>		25a. APR 23 1969 DATE		25b. REGISTRAR'S SIGNATURE <i>John Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
05613

CERTIFICATE OF DEATH

1
05608

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First Milton	Middle (NMM) Fried	Last	2a. DATE OF DEATH Month April	Day 4	Year 1969	2b. HOUR PM 7:30 M		
3. SEX Male		4. RACE White			5. DATE OF BIRTH 20 November 1915		6. AGE (in years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS 0		IF JUNIOR 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Economist		12b. KIND OF BUSINESS OR INDUSTRY Trade Union					
13a. USUAL RESIDENCE (Where deceased admission) STATE New York		13b. COUNTY V			13c. CITY OR TOWN New York		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 351 W. 24th Street			
14. FATHER'S NAME First Louis		Middle I.	Last Fried	15. MOTHER'S MAIDEN NAME First Helen			Middle		Last Gelfand			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Not Available			17. INFORMANT Bethesda, Md. 20014 Address The Medical Records, The Clinical Center,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebellar subarachnoid hemorrhage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal												
398 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) Acute renal failure 3 days DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic heart disease years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Systemic Lupus Erythematosis												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 19 March, 1969, to 4 April, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 April, 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE Joseph L. Goldstein		or P. DEGREE			ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED EX 5 April 1969	
22d. PHYSICIAN'S NAME (Type)		Joseph L. Goldstein, MD.			22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Apr. 5, 1969			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 3601-14 ST NW, WASH. D.C.			23d. LOCATION (City or Town) New York, N.Y.		(County)		
24. FUNERAL DIRECTOR B. Stauganby & Sons								25b. REGISTRAR'S SIGNATURE John Charles Judge				
								25c. REC'D BY REGISTRAR APR 10 1969				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05609

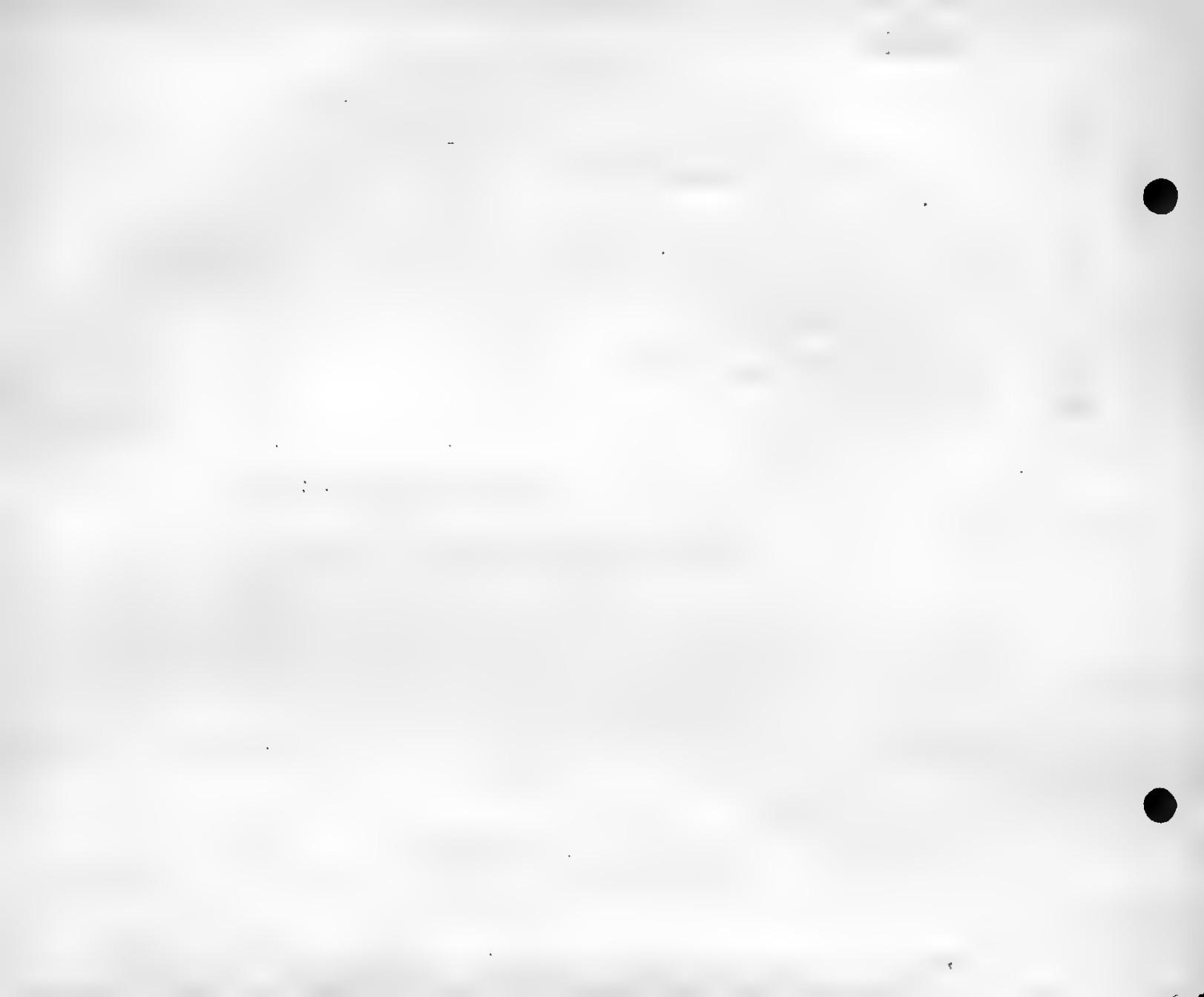
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, reburial, or removal, and in any event, within 72 hours after death.

Clerical - Dr. Grollman

MEDICAL CERTIFICATION

1. DECEASED NAME (Type or print)		First MAURICE	Middle NMN	Last FRIEDMAN	2a. DATE OF DEATH 4-19-69	Month	Day	Year	2b. HOUR 1:55 AM
4. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-23-14		6. AGE (in years 56st birthday)		IF UNDER 1 YEAR MONTHS VRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) D.C. BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY CO.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MARY. SAINT AND HOSP.		12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired) DRIVER BLUE LINE SIGN-SEEING CO.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13c. CITY OR TOWN SS		13d. INSIDE CITY L.H.T.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11385 COLUMBIA PIKE			
14. FATHER'S NAME ISAAC FRIEDMAN		15. MOTHER'S MAIDEN NAME First IDA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT HOSP RECORD		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4109</i> 4109			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>69</i> , to <i>4-19</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>April</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Albert H. Grollman MD</i>		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>4-19-69</i>					
22d. PHYSICIAN'S NAME & TITLE <i>Albert H. GROLLMAN</i>		22e. ADDRESS <i>1106 STRIKE ST. SILVER SPRING MD</i>							
23a. CEREMONY REMOVAL (Specify)		23b. DATE 4/21/69		23c. NAME OF CEMETERY OR CREMATORIAL OHEV SHLOMO TALMUD TORAH CEM. - HASH. D.C.		23d. LOCATION (City or Town) HASH. D.C.		(County)	(State)
24. FUNERAL DIRECTOR <i>Bernard Danzansky & Sons. 301-14th St. N.W. WASH. D.C.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>APR 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>W. Daniel Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05615

05610

Item 5 & 8 FilmGull 7/25/69 kk

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. **Page 4** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. **Page 4** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month	2b. HOUR Min.
<i>Lawrence E. Fuller</i>					<i>April 29 1969</i>	<i>4:30 PM</i>
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (in years last birthday)	
<i>MALE</i>		<i>white</i>		<i>1-9-85 1895</i>	74	YRS.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	
<i>Virginia</i>		<i>USA</i>		WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>Montgomery</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
<i>Bethesda</i>		<i>Suburban</i>			<i>RECOGNIZE</i>	
13a. RESIDENCE (Where deceased lived, if institution Reside before admission) STATE		13c. CITY OR TOWN		13d. INS OF CTY LIMITS?	13e. STREET AND NUMBER	
<i>Maryland</i>		<i>MONTGOMERY GAITHERSBURG</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<i>20 CHESTNUT ST.</i>	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
		<i>HENDERSON</i>		<i>FULLER</i>	<i>Unknown</i>	<i>GAITHERS Buca</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
(If yes give war or dates of service)					<i>C H F</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (b)	<i>acute myocardial infarction</i>	
				DUE TO, OR AS A CONSEQUENCE OF (c)	<i>ASHD</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. Month Day Year P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County
22a. I certify that (I) (the hospital) attended the deceased from <i>4-25 1969</i> to <i>4-29 1969</i> , that (I) (we) last saw the deceased alive on <i>4-28 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>John S. Soia</i>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22e. DATE SIGNED <i>4-29-69</i>
22d. PHYSICIAN'S NAME (Type)		John S. Soia		22e. ADDRESS <i>809 Viers Mill Road Rockville, Md</i>		
23a. BURIAL, CREMATION, REMOVAL/SHIPMENT		23b. DATE <i>4-3-69</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>RoseLawn Mem Gardens</i>		23d. LOCATION (City or Town) (County) <i>Mercer County W. Va</i>
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a. RECEIVED BY REGISTRAR DATE <i>MAY 5 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05616

05616

2b HOUR
A
11:15M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 2 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Karl	Middle Kennedy	Last Gaskins	2a. DATE OF DEATH Month April	Day 1	Year 1969	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
3. SEX Male	4. RACE Negro		S. DATE OF BIRTH 28 July 1961	6. AGE (In years last birthday) 7 YRS.			
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Virginia	13b. COUNTY Fauquier	13c. CITY OR TOWN Delaplane	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD, Box 52			
14. FATHER'S NAME William	First P.	Middle Gaskins	15. MOTHER'S MAIDEN NAME May		Middle Dorothy	Last Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none	17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20201					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Systemic Cryptococcosis DUE TO, OR AS A CONSEQUENCE OF (c) Acute Lymphocytic Leukemia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 22 August, 1960, to 1 April, 1961, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 April 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE Robert E. Gallagher, M.D.		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 1 April 1969				
22d. PHYSICIAN'S NAME (Type) Robert E. Gallagher, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md., 20201					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 5, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Morris		23d. LOCATION (City or Town) Hume	(County) Fauquier	(State) Va.	
24. FUNERAL DIRECTOR Royston Funeral Home	ADDRESS Marshall, Va.			25a. REC'D BY REGISTRAR DATE APR 7 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05612

1. DECEASED NAME (Type or Print)		First <i>Gilbert</i>	Middle <i>Davis</i>	Last <i>George</i>	2a. DATE KNOWN OF DEATH MATED	Month <i>4</i>	Day <i>8</i>	Year <i>1969</i>	2b. HOUR <i>2:00 P.M.</i>				
3. SEX <i>M.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH - <i>March 20 1925</i>	6. AGE (in years last birthday) <i>44 YRS</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>	8. IF UNDER 24 HRS DAYS <i>0</i>	9. HOURS <i>0</i>	10. MIN. <i>0</i>	2c. DATE PRONONCED DEAD Month <i>April</i>	Day <i>8</i>	Year <i>1969</i>	2d. HOUR <i>12:00 P.M.</i>		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Potomac</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8521 Victory Lane</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Salesman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		13e. STREET AND NUMBER <i>5805 Roosevelt St.</i>					
14. FATHER'S NAME First <i>Albert</i>		Middle <i>T.</i>	Last <i>George</i>	15. MOTHER'S MAIDEN NAME First <i>Dolly</i>		Middle <i></i>	Last <i>Davis</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i>		16b. SOCIAL SECURITY NO <i>W.W. II 578-26-3444</i>		17. INFORMANT <i>Mrs. Helen C. George, Bethesda</i>		5805 Roosevelt Street, Bethesda Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carbon Monoxide Poisoning -</i> Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Inhaling Auto Exhaust -</i> Due to, or as a consequence of (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>7 4/8 1969</i>		21c. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Garage of Home</i>		21d. LOCATION Street or R.F.D. No <i>8521 Victory Ln.</i>			City or Town <i>Potomac</i>				
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21f. COUNTY <i>Montgomery</i>		21g. STATE <i>Md.</i>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>April 8, 1969</i>			
EXAMINER'S NAME (Type)		JOHN G. BALL, M.D.		ADDRESS (Street, city, town, or county) <i>Montgomery Co. Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>4-9-69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) <i>Suitland</i>		(County) <i>Pr. Geo. Md.</i>		(State)			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Md.</i>		7557 Wisconsin Ave.		25a. RECD BY REGISTRAR <i>APR 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

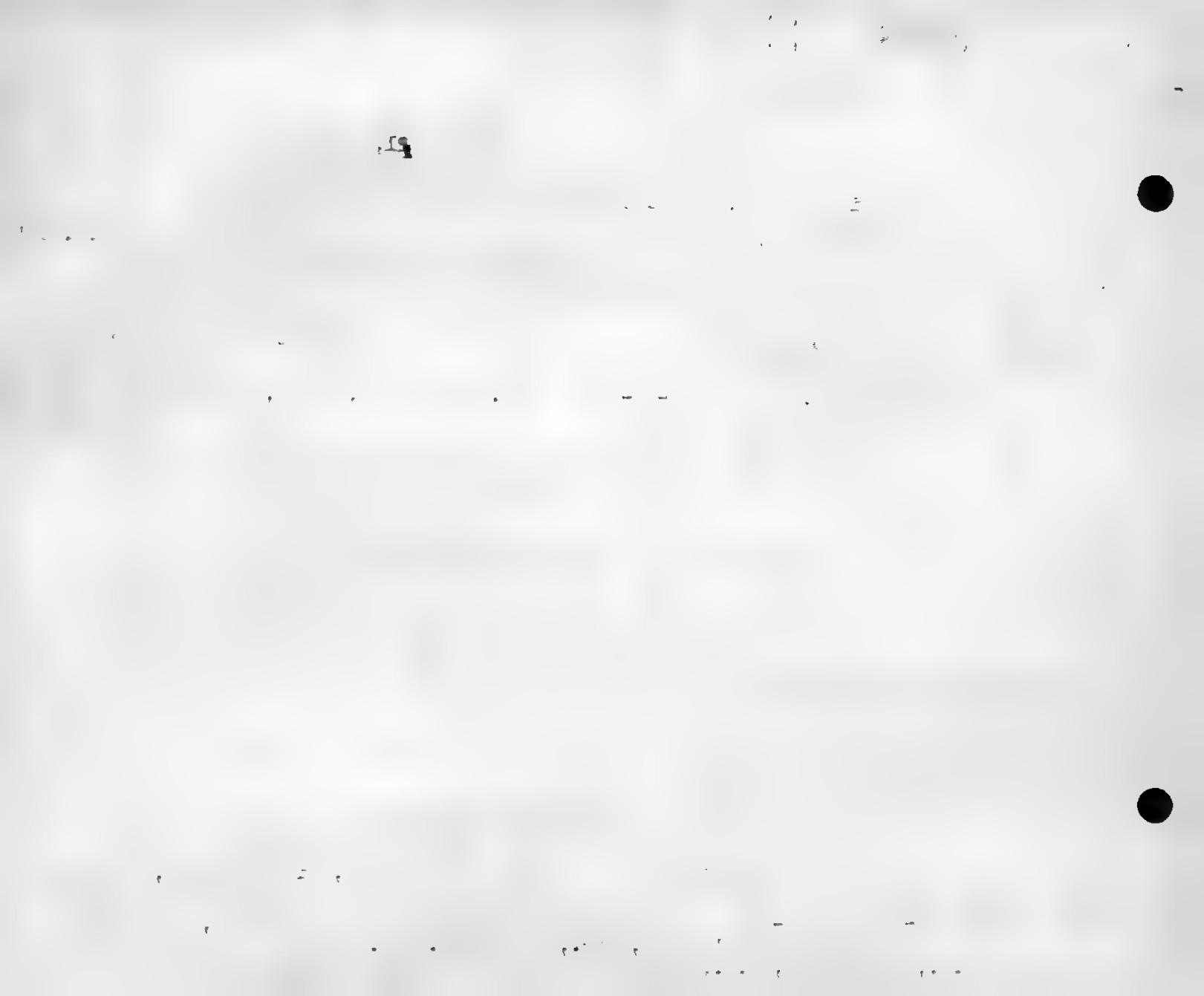
05618

05613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	Nicholas XXXXXX		Middle O.	Last Gerard	2a. DATE OF DEATH Month 4	Day 30	Year 69	2b. HOUR 7:39	
3. SEX Male	4. RACE White			S. DATE OF BIRTH April 21, 1922			6. AGE (in years last birthday) 47RS.	If UNDER 1 YEAR MONTHS DAYS	If UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) California	7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Administrator			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	SILVER Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Dr.,		13f. ZIP CODE 19607 Colefax		
14. FATHER'S NAME Nicholas V Gerard	First	Middle	Last	15. MOTHER'S MAIDEN NAME Marguerite	First	Middle	Last West		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO WW IT	16c. SOCIAL SECURITY NO 186-16-7742		17. INFORMANT Mrs. Ann Gerard, Widow, same as item #13	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) Massive myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from July 19 67, to April 30, 19 69, that (I) (we) last saw the deceased alive on May 27 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Richard Delaney</i>	DEGREE ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED May 6 1969		
22d. PHYSICIAN'S NAME (Type) Richard Delaney	22e. ADDRESS 4323 Harvard, Silver Spring, Maryland								
23a. BURIAL, CREMATION, REMOVAL, ETC. Removal 5-1-1969	23b. DATE 5-1-1969	23c. NAME OF CEMETERY OR CREMATORIAL West Wyoming Cemetery	23d. LOCATION (City or Town) West Wyoming, Pennsylvania		(County)		(State)		
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C., 20016	REGISTRAR DATE MAY 6 1969		25b. REGISTRAR'S SIGNATURE <i>Richard Delaney</i>						



05614

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)	First SARAH	Middle K.	Last Ginsburg	2a. DATE OF DEATH Month X	Day X	Year 69	2b. HOUR 12 PM
3. SEX Female	4. RACE White	S. DATE OF BIRTH 1898	6. AGE (in years last birthday) 70 68 yrs.	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 MRS. HOURS 0	
7a. BIRTHPLACE (State or foreign country) Russia	7b. CITIZEN OF WHAT COUNTRY U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY SSPG.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS No	13e. STREET AND NUMBER 11715 OAKLEAF DR.			
14. FATHER'S NAME First YITZHAIC	Middle Kastrow	Last	15. MOTHER'S MAIDEN NAME First Diane	Middle	Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO 578-50-8150	17. INFORMANT MANNY GINSBURG	10107 Devere Add Court, S.S. Md. 59444971B.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia - Klebsiella - Pseudomonas				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 - 3 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 4				DUE TO, OR AS A CONSEQUENCE OF 4			
(b)				DUE TO, OR AS A CONSEQUENCE OF 4			
(c)				DUE TO, OR AS A CONSEQUENCE OF 4			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Arteriosclerosis = Cerebral Atrophy							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 68 , to 4-4-69 , that (I) (we) last saw the deceased alive on 4-3-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE G. B. Cushner, M.D.	22c. DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED 4-4-69		
22d. PHYSICIAN'S NAME (Type) G. B. Cushner, M.D.	22e. ADDRESS 1161 New Hampshire Avenue Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-6-69	23c. NAME OF CEMETERY OR CREMATORIAL G.C. Com., Inc.	23d. LOCATION (City or Town) Hyattsville MD.	(County) MD.	(State)		
24. FUNERAL DIRECTOR Boyle's Funeral Home	ADDRESS 4217-9 Street	25a. REC'D BY REGISTRAR DATE APR. 8 1969	25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05620

05615

CERTIFICATE OF DEATH

4
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Dominic</i>	Middle <i>E.</i>	Last <i>Gioffre Jr.</i>	2a. DATE OF DEATH Month <i>April</i>	Doy <i>11</i>	Year <i>1969</i>	2b. HOUR <i>1100 P M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>April 24, 1949</i>		6. AGE (in years last birthday) <i>19</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> <i>Washington D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Montgomery County Md.</i>				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital of Silver Spring</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13c. CITY OR TOWN <i>Upper Marlboro</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>9901 Central Avenue</i>				
14. FATHER'S NAME First <i>Dominic</i>	Middle <i>E</i>	Last <i>Gioffre</i>	15. MOTHER'S MAIDEN NAME First <i>Dorothy</i>	Middle <i></i>	Last <i>Sweeney</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <input type="checkbox"/>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17 INFORMANT <i>Dominic E Gioffre, Sr</i>	Address <i>9901 Central Ave</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>liver failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>metastatic jotted carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>4/9</i> , 19 <i>69</i> , to <i>4/11</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/10</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Lewis Hilliard Jones MD</i>	MD DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/11/69</i>			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <i>3906 Bel Pre Rd. Silver Spring MD</i>		23d. LOCATION (City or Town) <i>Clinton</i>		(County) <i>PG</i>	(State) <i>Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4-14-1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Resurrection Cemetery</i>					
24. FUNERAL DIRECTOR Robert E Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland	25a. REC'D BY REGISTRAR DATE APR 15 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

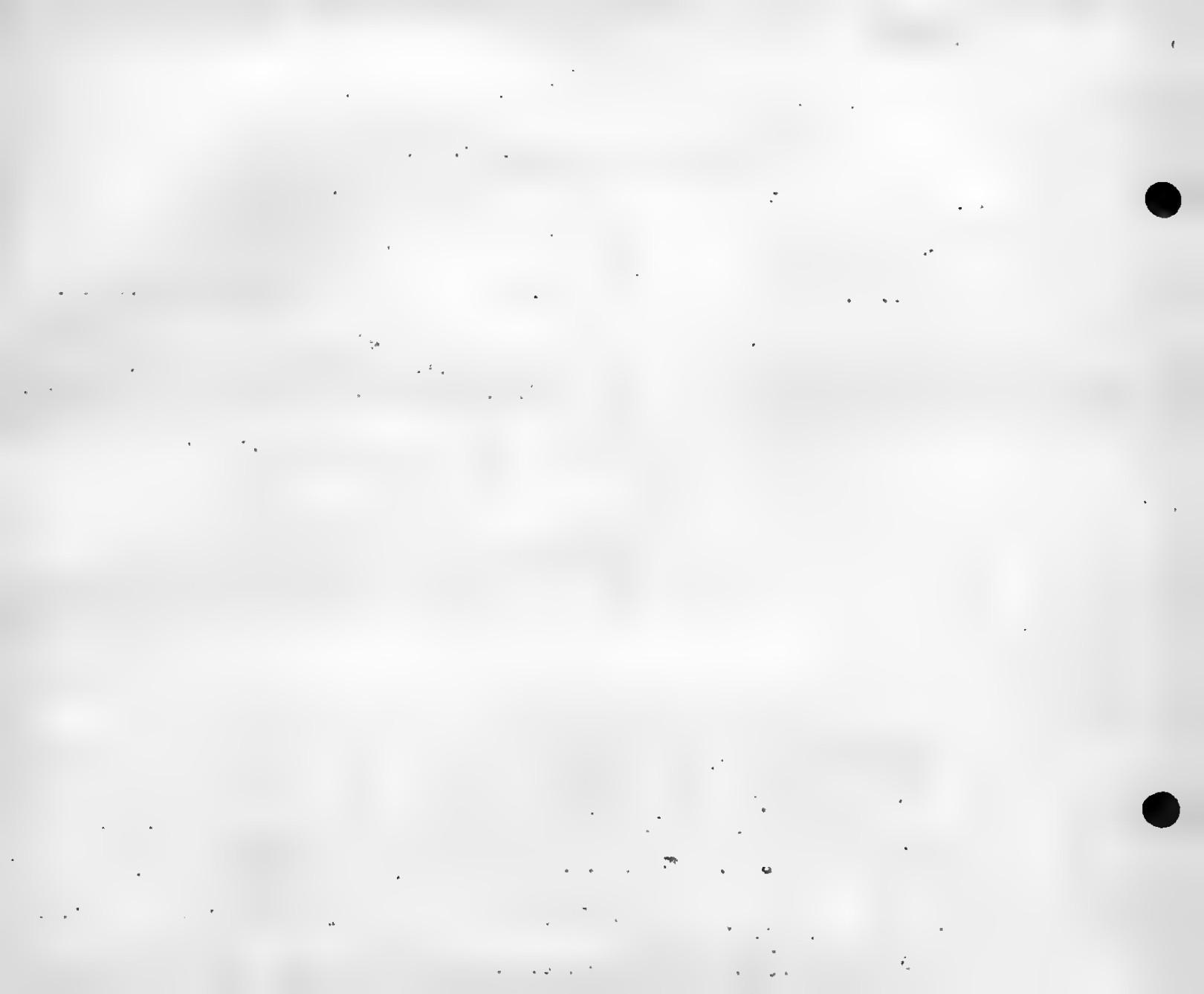
05616

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Victor	Middle H	Last GOODMAN	2a. DATE OF DEATH April Month 21 Day Year 69 2b. HOUR 409P M
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH Sept. 28, 1927		6. AGE (In years last birthday) 41 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Montgomery
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.	13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 928 Ingraham St., N.W.	
14. FATHER'S NAME James	First G.	Middle Goodman	Last Letha	Middle Holtzclaw
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. WWII, Korea	17. INFORMANT S.E., Washington, Address Mrs. Berlyne A. Handy, 34th & Alabama Aves.		D.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure by history with acute pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF <u>edema; status postoperative gastrectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from Mar. 19, 1969, to Apr. 21, 1969, that (I) (we) last saw the deceased alive on Apr. 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and did not) view the body after death.				
22b. SIGNATURE <u>Donald K. Roeder, M.D.</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Apr. 23, 1969
22d. PHYSICIAN'S NAME (Type) Donald K. ROEDER, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/69	23c. NAME OF CEMETERY OR CREMATORIAL Salisbury National Cemetery	23d. LOCATION (City or Town) Salisbury, (County) N.C. (State)
24. FUNERAL DIRECTOR Butler Funeral Home 3900 Georgia Ave., N.W. Washington, D. C.		ADDRESS	25a. RECD BY REGISTRAR APR 25 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05622

05617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 100 M
<i>Gerry Parker Grody</i>			<i>Parker</i>	<i>Grody</i>	<i>April 28 1969</i>	<i>100 M</i>	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday) MONTHS DAYS HOURS MIN	
<i>Male</i>		<i>White</i>	<i>4/24/1912</i>			<i>57 YRS</i>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH	
<i>Wash DC</i>		<i>USA</i>				<i>Montgomery</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
<i>Bethesda</i>		<i>Suburban</i>			<i>Retired</i>	<i>Residence</i>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
<i>Md</i>		<i>Montgomery</i>	<i>Bethesda</i>	<i>NO</i>	<i>7820 Tilbury St.</i>		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>Gerry J. Grody</i>		<i>Gerry</i>	<i>J.</i>	<i>Grody</i>	<i>Cornelia</i>	<i>Years</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown		16b. SOCIAL SECURITY NO.			17. INFORMANT	Address <i>49111 Shadowwood Dr.</i>	
<i>No</i>					<i>Son Dennis M. Grody</i>	<i>Gaithersburg, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of Liver</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1928</i> to <i>4-28-69</i> , that (I) (we) last saw the deceased alive on <i>4-28-69</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <i>Paul D. Cantor MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/28/69</i>				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>4709 Montgomery Ave Bethesda, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-1-69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) <i>Washington, D. C.</i>	(County) (State)	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>	25a. RECD BY REGISTRAR <i>MAY 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>		



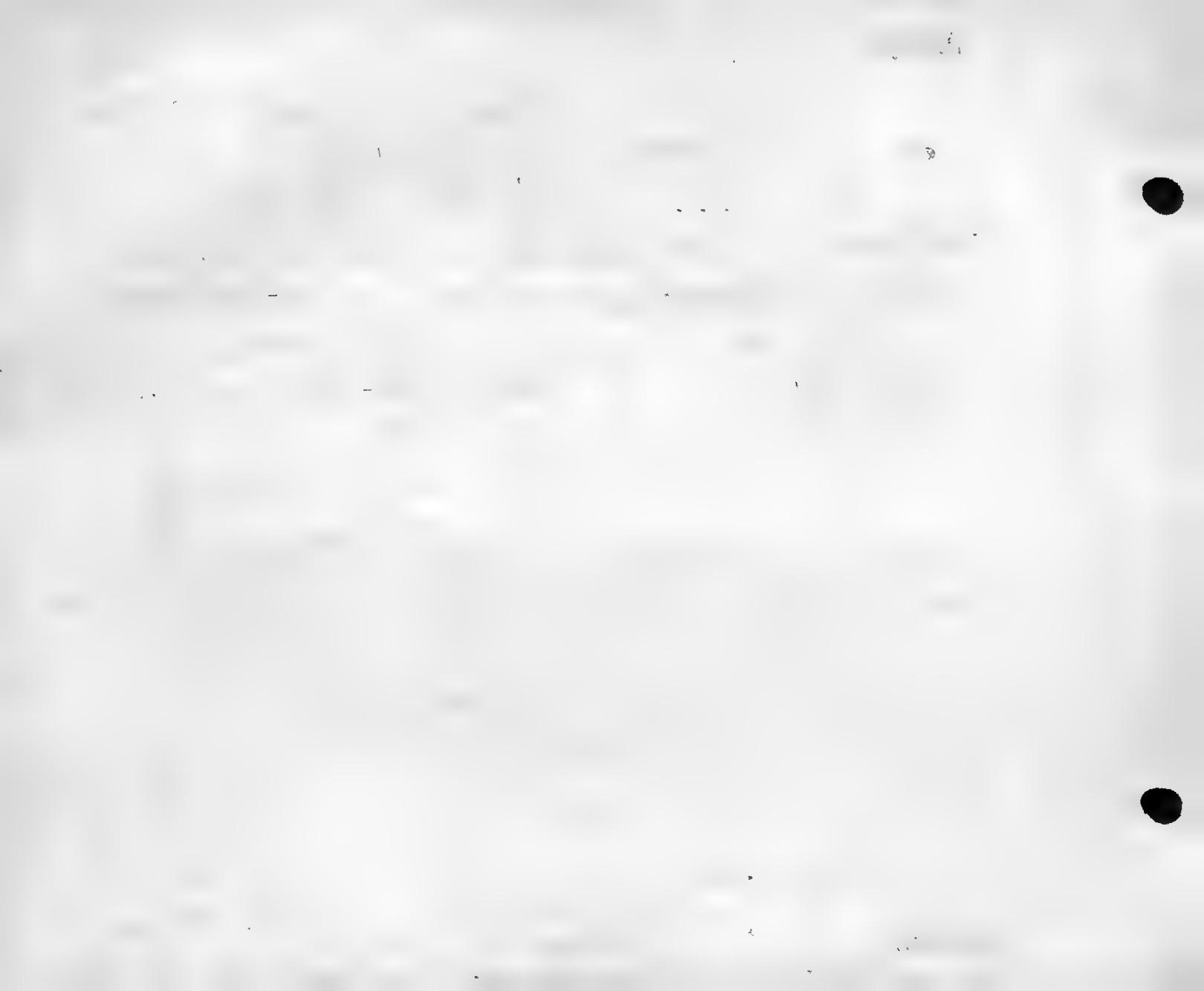
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10
05623

05618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Albert</i>	Middle <i>R</i>	Lost <i>Graf</i>	20. DATE OF DEATH Month <i>April</i>	20. HOUR Day <i>20</i> Year <i>1969</i>	2b. HOUR IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 31, 1900</i>		6. AGE (In years last birthday) <i>69</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3502 Chiswick Court</i>		12a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Economist - Dept. of Agriculture</i>		
13a. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>3502-Chiswick Court</i>		
14. FATHER'S NAME First <i>Henry</i> Middle <i>Graf</i> Lost		15. MOTHER'S MAIDEN NAME First Middle <i>Amelia</i> Last <i>Frohnader</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>		16b. SOCIAL SECURITY NO <i>WWI</i>		17. INFORMANT (Wife) <i>Helen L. Graf - 3502 Chiswick Ct., Silver</i>		Address <i>Spring, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost! (b) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Pancreas</i>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>12/14</i> , 19 <i>68</i> , to <i>4/10</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Robert A. Barnett, M.D.</i>		DEGREE ATTENDING PHYS	22c. DATE SIGNED <i>4/20/69</i>	MED. DIRECTOR	STAFF PHYS			
22d. PHYSICIAN'S NAME (Type) <i>Robert A. Barnett</i>		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Apr. 23, 1969</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Suitland, Maryland</i>		
24a. FUNERAL DIRECTOR <i>Paul Smith</i>		24b. ADDRESS <i>8434 Georgia Avenue</i>		24c. REG'D BY REGISTRAR <i>APR 24 1969</i>		24d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
25a. FUNERAL DIRECTOR <i>Paul Smith</i>		25b. ADDRESS <i>Warren E. Humphrey, Inc. Silver Spring, Md.</i>		25c. REG'D BY REGISTRAR <i>APR 24 1969</i>		25d. REGISTRAR'S SIGNATURE		



05624

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 FilmG412 5/9/69 kk

CERTIFICATE OF DEATH

05619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Baby	Middle Girl	Last Graham	2a. DATE OF DEATH Month April	Day 28	Year 1969	2b. HOUR P 3:45PM	
3. SEX FEMALE		4 RACE Negro		S. DATE OF BIRTH 4/28/69	6. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR MONTHS —	IF UNDER 24 HRS. HOURS 30	MIN 30
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 301 N. Adams st., apt. 29			
14. FATHER'S NAME First Rita		Middle Diane	Last Graham	15. MOTHER'S MAIDEN NAME First Rita		Middle Diane	Last Graham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Records Montgomery General Hospital, Olney, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, brain, pneumonia pneum</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 30m (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF 30m (c) <i>Pneumonia</i> 30m								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Congenital heart disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM P.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No 4129	City or Town 1969	County 19	State		
22a. I certify that (I) (this hospital) attended the deceased from 4/28/69 , to 4/29/69 , that (I) (we) last saw the deceased alive on 4/28/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles H. Ligon</i>		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/29/69			
22d. PHYSICIAN'S NAME (Type) Charles H. Ligon, M.D.		22e. ADDRESS Sandy Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) 4/28/69		23b. DATE 4/28/69		23c. NAME OF CEMETERY OR CREMATORIAL Hunter Laboratory		23d. LOCATION (City or Town) Washington, D.C.		(County) —	(State) —
24. FUNERAL DIRECTOR ADDRESS				25a. RECD. BY REGISTRAR DATE MAY 1 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05625

CERTIFICATE OF DEATH

05620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.)

1. DECEASED NAME (Type or print)	First Cornelia	Middle Isabelle	Last Griffith	2a. DATE OF DEATH April Month 18 Day 1969 Year 6:30 PM	2b. HOUR P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 7, 1877		6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13c. CITY OR TOWN Laytonsville	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6010 Laytonsville-Olney Rd.		
13b. COUNTY Montgomery					
14. FATHER'S NAME First John	Middle Thomas	Last Warfield	15. MOTHER'S MAIDEN NAME First Middle Rachel V. Dorsey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 213-38-1071	17. INFORMANT Records of Montgomery General Hospital, Olney, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure. Days</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF <i>A.H.D.</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>double stenosis - dysrhythmia, pulmonary, multiple</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERAT. ON WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>Jack Schumacher</i>	DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <i>4-10-69</i>		
22d. PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.	22e. ADDRESS 105 Russell Ave., Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-22-69	23c. NAME OF CEMETERY OR CREMATORIAL Goshen	23d. LOCATION (City or Town) Goshen	(County) Mont.	(State) Md.
24. FUNERAL DIRECTOR Francis H. Barber	ADDRESS Laytonsville, Md.	25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 30M REV. 1/68					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05626

05621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Jacob	Middle	Last Hackerman	2a. DATE OF DEATH Month April	Day 2	2b. HOUR 3 P.M.		
3. SEX Male	4. RACE White	S. DATE OF BIRTH April 19, 1883	6. AGE (In years last birthday) 83 YRS.	1f. UNDER 1 YEAR MONTHS 0			1f. UNDER 24 HRS. DAYS 0	
7a. BIRTHPLACE (State or foreign country) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH MONTGOMERY COUNTY Md.					
10. CITY OR TOWN OF DEATH Rockville,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PODMAL VALLEY NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Freeman	12b. KIND OF BUSINESS OR INDUSTRY Walking Factory					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland	13b. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6605 Seelkirk Drive					
14. FATHER'S NAME Jacob	15. MOTHER'S MAIDEN NAME Tina	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO. 272-01-5705	17. INFORMANT Mrs. Joseph Lieberman-6605 Seelkirk	Address (Bethesda MD)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of esophagus, primary</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>— ARTERIOSCLEROTIC HEART DISEASE</u>								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (his hospital) attended the deceased from <u>February 20 1969</u> , to <u>April 2 1969</u> , that (I) (we) last saw the deceased alive on <u>March 28 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Stanley J. Talpers M.D.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4-2-69			
22d. PHYSICIAN'S NAME (Type) STANLEY J. TALPERS		22e. ADDRESS 2141 K ST. NW. WASH D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE April 6 69	23c. NAME OF CEMETERY OR CREMATORIAL Kings Service	23d. LOCATION (City or Town) Baltimore, Md.	(County)			(State)
24. FUNERAL DIRECTOR El Gluson & Bros - 6010 Reseda Dr.		ADDRESS JAC	Rd.	25a. REC'D BY REGISTRAR APR 9 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			
30M REV VR A III								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05627

CERTIFICATE OF DEATH

05628

*Drs. Delaney, Roaf Medical Examiners, Inc.
concerning circumstances of death
one Kinsman sign
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.*

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)		First <u>Hortense</u>	Middle <u>M.</u>	Lost	2a. DATE OF DEATH Month <u>April</u>	Day <u>5</u>	Year <u>69</u>	2b. HOUR 15 ¹⁵	
3. SEX <u>F</u>		4 RACE <u>White</u>	5. DATE OF BIRTH <u>Sept. 27, 1900</u>		6. AGE (in years last birthday) <u>68</u>		IF UNDER 1 YEAR MONTHS <u>0</u>	IF UNDER 24 HRS. HOURS <u>0</u>	
7a BIRTHPLACE (State or foreign country) <u>Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u>				
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u>		12a. US/JAL RESIDENCE (Where deceased lived, if institution admission) <u>STATE Md.</u> Residence before <u>13c CITY OR TOWN MONTGOMERY ROCKVILLE</u>		12b. US/JAL RESIDENCE (Where deceased lived, if institution admission) <u>STATE Md.</u> Residence before <u>13d INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/></u>		13e STREET AND NUMBER <u>12608 Parkland Dr</u>	
14 FATHER'S NAME First <u>W. B.</u> Middle <u>Bacon</u> Lost		15 MOTHER'S MAIDEN NAME First <u>Lena</u> Middle <u></u> Lost							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>577-52-2335</u>		17 INFORMANT <u>Gloria Lattea - Daughter</u>		Address <u>Rockville, Md.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction left ventricle</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Atherosclerosis, coronary arteries.</u> DUE TO, OR AS A CONSEQUENCE OF (i) <u>Hypertensive Heart Disease</u> Undetermined									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)-(c) <u>Generalized Arteriosclerosis, Diverticulosis of Colon, Arteriosclerosis, Generalized</u> <u>Arteriosclerosis, Hypertension</u>									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>10</u> Month <u>July</u> Day <u>19</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>69</u> , to <u>APR 5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>APR 2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George L. Ball</u>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>Apr 5 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		22e. ADDRESS <u>10620 Georgia Avenue Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 9, 1969</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) <u>Washington, D.C.</u>		(County) <u>D.C.</u>	(State) <u>D.C.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		24b. ADDRESS <u>8474 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-12-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05623

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR	
Lois GAIL HAHN						April 28	1969	10:00	A.M.		
3. SEX	4 RACE	5 DATE OF BIRTH	6. AGE (in years at birthday) YRS	IF UNDER MONTHS	YEAR DAYS	IF UNDER 24 HRS HOURS	MIN.				
Female	WHITE	3/31/42	27					2d HOUR			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			Montgomery			Rockville	YES <input type="checkbox"/> NO <input type="checkbox"/>	8705 Post Oak Rd.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last			
Samuel A. Hillman					Jeanette			Segal.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
(If yes give war or dates of service)						Husband - Peter Hahn					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pet Hahn</u> Barbiturate poisoning											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
DUE TO, OR AS A CONSEQUENCE OF (b) Overdose of Tuinal											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:15 PM 4/28 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Took overdose of Tuinal					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. 8705 Post Oak Rd. Rockville Montg. Md.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											22b. DATE SIGNED April 28, 1969
ACTUAL SIGNATURE <u>John S. Bell</u>		EXAMINER'S NAME (Type)		M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/29/69		23c. NAME OF CEMETERY OR CREMATORIAL King David Mem. Garden			23d. LOCATION (City or Town) Falls Church, Va.		(County) (State)		
24. FUNERAL DIRECTOR Bernard Danzansky & Sons 3501 14th St., N.W., Wash., D.C.		ADDRESS			25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE <u>Bernard Danzansky</u>				



05629

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First AMY	Middle ESTELLE	Last HANLEIN	2a. DATE OF DEATH Month 4 Day 3 Year 69	2b. HOUR 8:13 p.m.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH Dec. 27, 1891		6. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY COUNTY	
10. CITY OR TOWN OF DEATH TAKOMA PARK, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or at home) ASHLEY SANITARIUM & HOSPITAL	12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA PK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7777 MAPLE AVENUE	
14. FATHER'S NAME JOHN	Middle F. SULLIVAN	Last	15. MOTHER'S MAIDEN NAME ELENORA	Middle	Last DANTE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NONE	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-54-9380	17. INFORMANT ISADORE HANLEIN,	Address SAME AS # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured aortic aneurysm</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town	County State
22a. I certify that (I) (This hospital) attended the deceased from 3/12/69 , to 4/3/69 , that (I) (we) last saw the deceased alive on 3/21/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (she) did not view the body after death.					
22b. SIGNATURE <i>Raymond C. Kirchner, MD</i>		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4-4-69
22d. PHYSICIAN'S NAME (Type) Raymond C. Kirchner, MD		22e. ADDRESS 6480 New Hampshire Ave., Tak. Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/7/1969	23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEMETERY	23d. LOCATION (City or Town) BLADENSBURG, MARYLAND	(County) (State)
24. FUNERAL DIRECTOR <i>Joseph Pawlisinski, Jr.</i>		ADDRESS 5130 WISC.AVE., N.W.,	25a. REC'D BY REGISTRAR APR 7 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



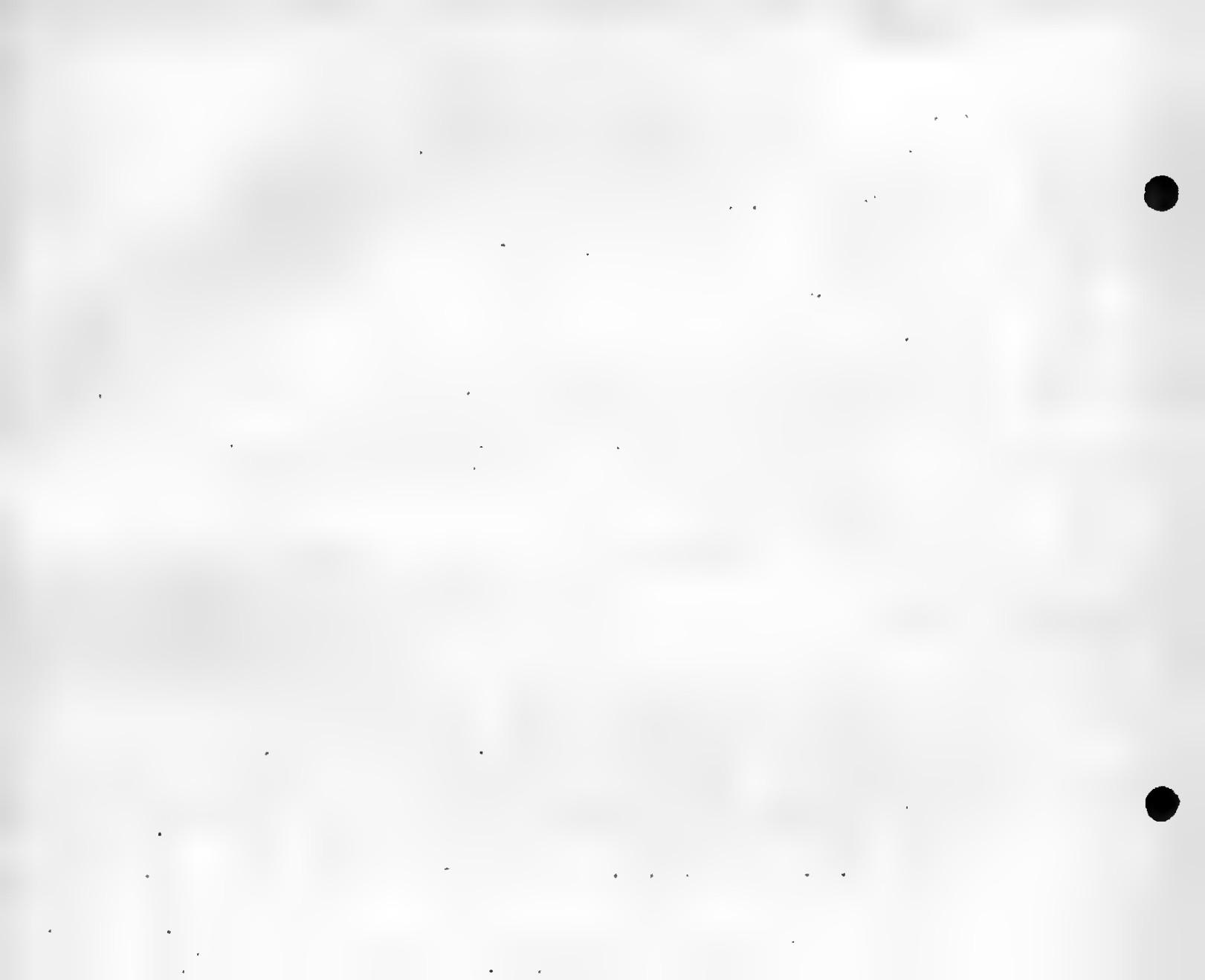
1
05630

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Virginia	Middle Blunt	Last HARMON	2a. DATE OF DEATH Month April	Day 15	Year 1969	2b. HOUR 1247 P.M.	
3. SEX Female		4 RACE Caucasian		S. DATE OF BIRTH June 20, 1919	6. AGE (In years lost, birthday) 49		IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		Md		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida		13c. CITY OR TOWN Monroe		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Box 78				
14. FATHER'S NAME First Joseph		Middle Blunt	Lost	15. MOTHER'S MAIDEN NAME First Anna		Middle Spaulding	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown No		16b. SOCIAL SECURITY NO. 578 12 6824		17. INFORMANT Roy L. Harmon, Box 78 Summerland Key, Fla		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative repair of atrial septal defect DUE TO, OR AS A CONSEQUENCE OF with acute dissection of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION 15 Apr 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atrial septal defect		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 25, 1969 , to Apr. 15, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Apr. 15, 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> not view the body after death.									
22b. SIGNATURE <i>Robert C. Ashworth</i>		DEGREE Phys	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED Apr. 17, 1969					
22d. PHYSICIAN'S NAME (Type) H. E. ASHWORTH, M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-69		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) Arlington		(County) Arlington	(State) VA.
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home ADDRESS 1500 West Braddock Road, Alexandria, Va.				25a. REC'D BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE <i>Robert V. Underwood</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 [4]
30M REV. 1/68

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR	
Prant		GenTrude		HARRINGTON	April	19	69	8:30 AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.		
Female	Wh. To	MAR. 20, 1886		83	YRS.	MONTHS	DAYS	HOURLS	M N	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		2407 GLEN ALLEN AVE.		HOUSEWIFE		At HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2407 GLEN ALLEN AVE.		
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle	Last			
CHARLES		F.	LITTLE	MARGARET		—	BENNETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address				
No —		518-36-3601		CHAMILLE SHERMAN		CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> minutes										
43 ⁵ DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) <u>Cerebral arteriosclerosis</u> 1 yr.										
stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Cerebral arteriosclerosis</u>										
(c) <u>Generalized arteriosclerosis</u> 4 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Hyper Tension</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 12, 1969</u> , to <u>9/19</u> , 1969, that (I) (we) last saw the deceased alive on <u>4/18</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Raymond T. Benwick MD</u>										
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			22c. DATE SIGNED					
Raymond T. Benwick MD		4115 Colie Dr. Wheaton, Md			9/19/69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		4/22/69		ROCK CREEK CEM.		WASHINGTON, D.C.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Jos. GAWLER'S SONS, 5130 WISCONSIN AVE.		WASHING-TON, D.C.		APR 23 1969		James, Judge				



05632

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First Arnold	Middle E.	Last Harris	2a. DATE OF DEATH April Month 5, Day 1969	2b. HOUR M		
3. SEX Male		4 RACE White	5. DATE OF BIRTH Aug. 17, 1902			6. AGE (In years last birthday) 66	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Coal Miner			12b. KIND OF BUSINESS OR INDUSTRY 12819 Twinbrook Pkwy.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 12819 Twinbrook Pkwy.		
14. FATHER'S NAME William Harris		First Middle Last	15. MOTHER'S MAIDEN NAME Minnie Harrington						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 403 05 3270	17. INFORMANT Carl Harris - son - 512 College Pkwy. Rock			Address Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular collapse</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> 10 hours (c) <u>Atherosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1969</u> to <u>April 6, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edward J. Richards</u>									
22d. PHYSICIAN'S NAME (Type) Edward J. Richards		22e. ADDRESS 1010 Georgia Avenue, Silver Spring, M			22f. DATE SIGNED 4-6-69				
23a. BURIAL, CREMATION, Burial (Specify)		23b. DATE 4/8/69	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION (City or Town) Rockville, Maryland (County) (State)			
24. FUNERAL DIRECTOR Tyson Wheeler F. H.		ADDRESS 1331 Rockville Pike Rockville, Maryland			25a. REC'D BY REGISTRAR APR 11 1969	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
30M REV 6-68									



05633

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05628

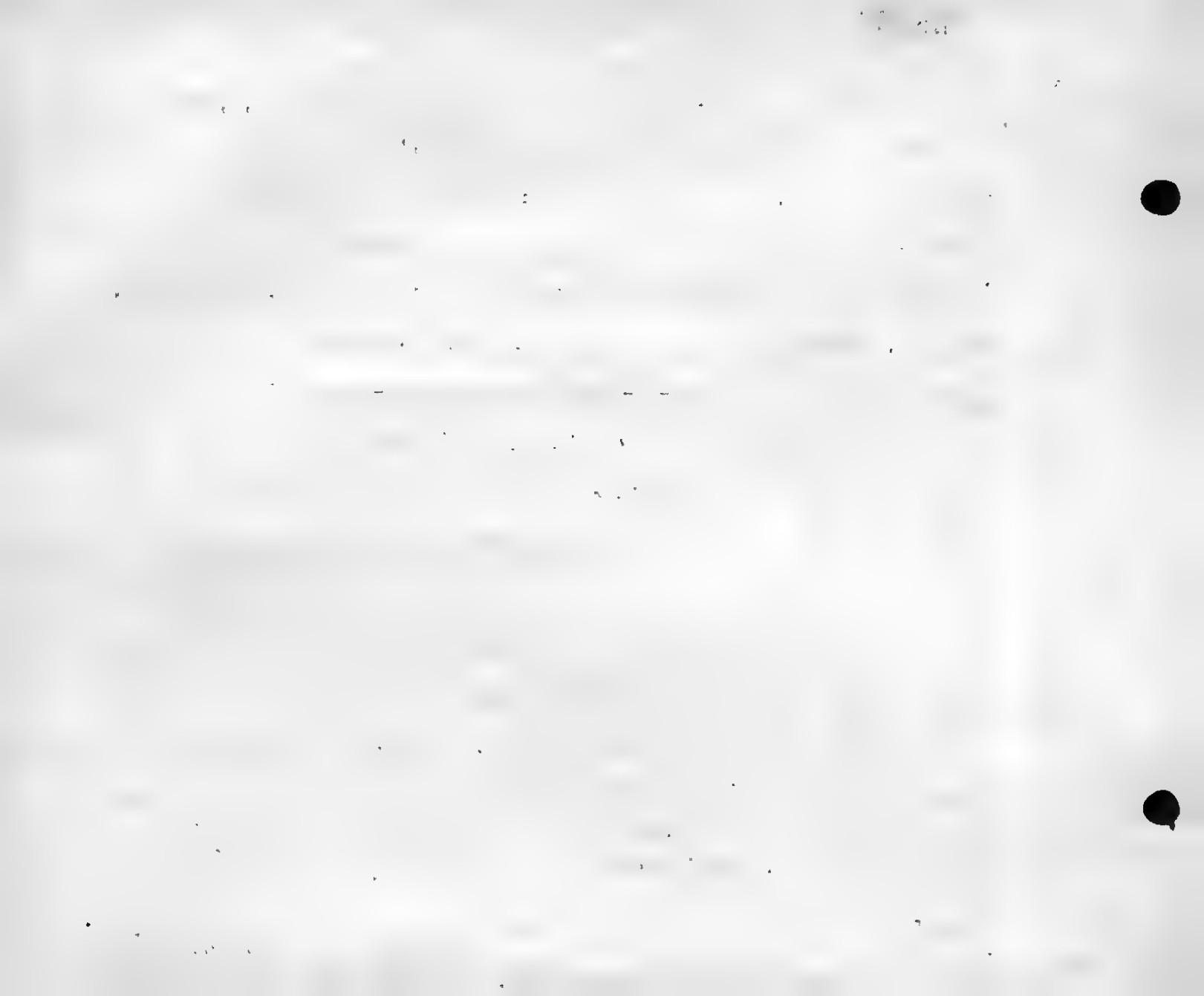
Item#11 FilrG411 4/18/69 km

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First ERNEST	Middle L.	Last HARTMAN	2a. DATE OF DEATH Month April Day 7, 1969	Year 1969	2b. HOUR 6 P.M.			
3. SEX Male		4. RACE White		S. DATE OF BIRTH April 10, 1883	6. AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INST TUTION (If not in hospital give street address) South Van Buren St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13c. CITY OR TOWN Montgomery		13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 125 S. Van Buren St.					
14. FATHER'S NAME George P. Hartman		15. MOTHER'S MAIDEN NAME Sue Kate Eicholtz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 188-12-3684A		17. INFORMANT Herman Hartman-Item # 13		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4550		DUE TO, OR AS A CONSEQUENCE OF CELEBRAL + HYPERTENSION				12 Hours				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) OBESITY ESSENTIAL HYPERTENSION				20 years				
(c) ARTERIOSCLEROSIS						25 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1968 , to APRIL 7, 1969 , that (I) (we) last saw the deceased alive on April 1, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Gordon S. Rosenberger</i>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED April 7, 1969		
22g. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22h. ADDRESS 361 West Montgomery Ave Rockville, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/10/69		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Cem		23d. LOCATION (City or Town) Arendtsville		(County) Pa.	(State)	
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS Funeral Home 1331 Rockville Rockville, Md.		25a. RECD BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 30M REV. 1/68										



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05634

05629

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Ruth	Middle NMN	Last Havens	2a. DATE OF DEATH Month 4	Day 10	Year 1969	2b. HOUR 6:50 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 2-25-89		6. AGE (in years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED WIDOWED		9. COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Teaching	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Ashton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME James	First J.	Middle Shoemaker	Last -	15. MOTHER'S MAIDEN NAME Helen	First Reese	Middle -	Last -
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. - - -	17. INFORMANT Records of: Montgomery General Hospital		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 h - 6 days			
(b) Mesenteric thrombosis (post Surg.) (c) Adeno carcinoma of Colon							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 4/4/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstruction due to Colon	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building Etc)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 4/1/69 to 4/10/69, that (I) (we) last saw the deceased alive on 4/10/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Charles H. Liron M.D.	DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/11/69		
22d. PHYSICIAN'S NAME (Type) Dr. Charles H. Liron M.D.	22e. ADDRESS Sandy Spring, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) 4/4/69	23b. DATE 4/4/69	23c. NAME OF CEMETERY OR CREMATORIAL Lee Funeral Home	23d. LOCATION (City or Town) Wash. D.C.		23e. (County)	(State)	
24. FUNERAL DIRECTOR Francis H. Parker, Laytonsville, Md.	ADDRESS Francis H. Parker, Laytonsville, Md.	25a. REG'D BY REGISTRAR APR 18 1969	25b. REGISTRAR'S SIGNATURE Charles J. Parker				



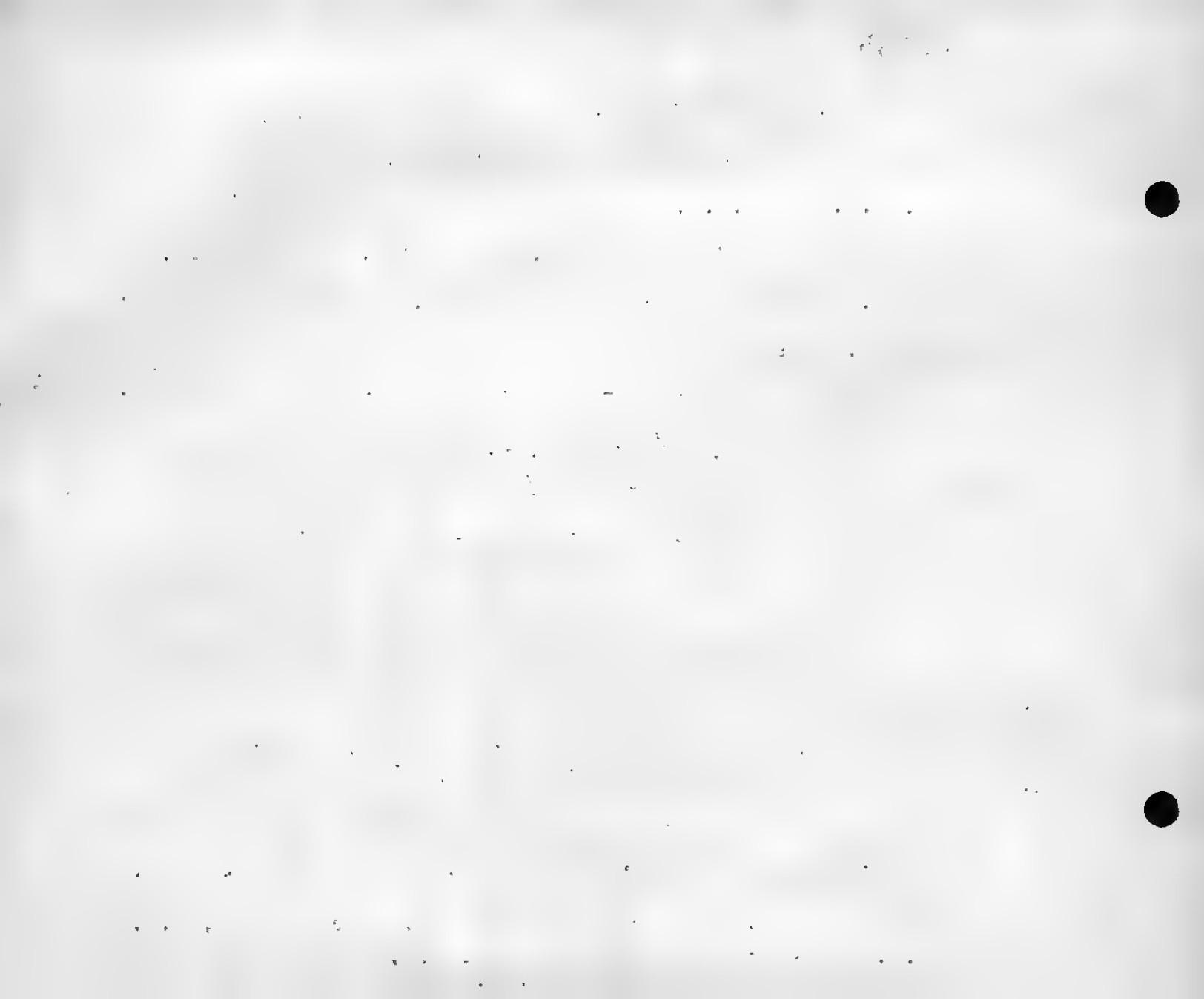
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05630

05635

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR 1/30 M
LEONARD MEREDITH				HAYS	4/7/69	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
male	white	11/29/11		57 YRS		
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Labor-U.S. Government	
7a. Wash. D.C.	7b. U.S.A.					
10. CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8715 1st Ave.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lept. of Labor-U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8715 1st Ave.		
14. FATHER'S NAME First Bernard F. Hays	Middle	Lost	15. MOTHER'S MAIDEN NAME First Mary Elizabeth Maddox	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-54-7492	17 INFORMANT Charles Hays-1136 Hornell Dr. Silver Spring, Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH miss. 1 day years.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from May , 1967, to April 1 , 1969, that (I) (we) last saw the deceased alive on 4/8 , 1969, and that in (In) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.						
22b. SIGNATURE Harold W. Draper	m.o. DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/7/69			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/10/69	23c. NAME OF CEMETERY OR CREMATORIAL Congressional Cemetery	23d. LOCATION (City or Town) washington, D.C.	(County)	(State)	
24. FUNERAL DIRECTOR The S.H. Hines Company	ADDRESS 2901 14th St. Washington, D.C.	25a. REG'D BY REGISTRAR N. APR 9 1969	25b. REGISTRAR'S SIGNATURE James Judge			
DATE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

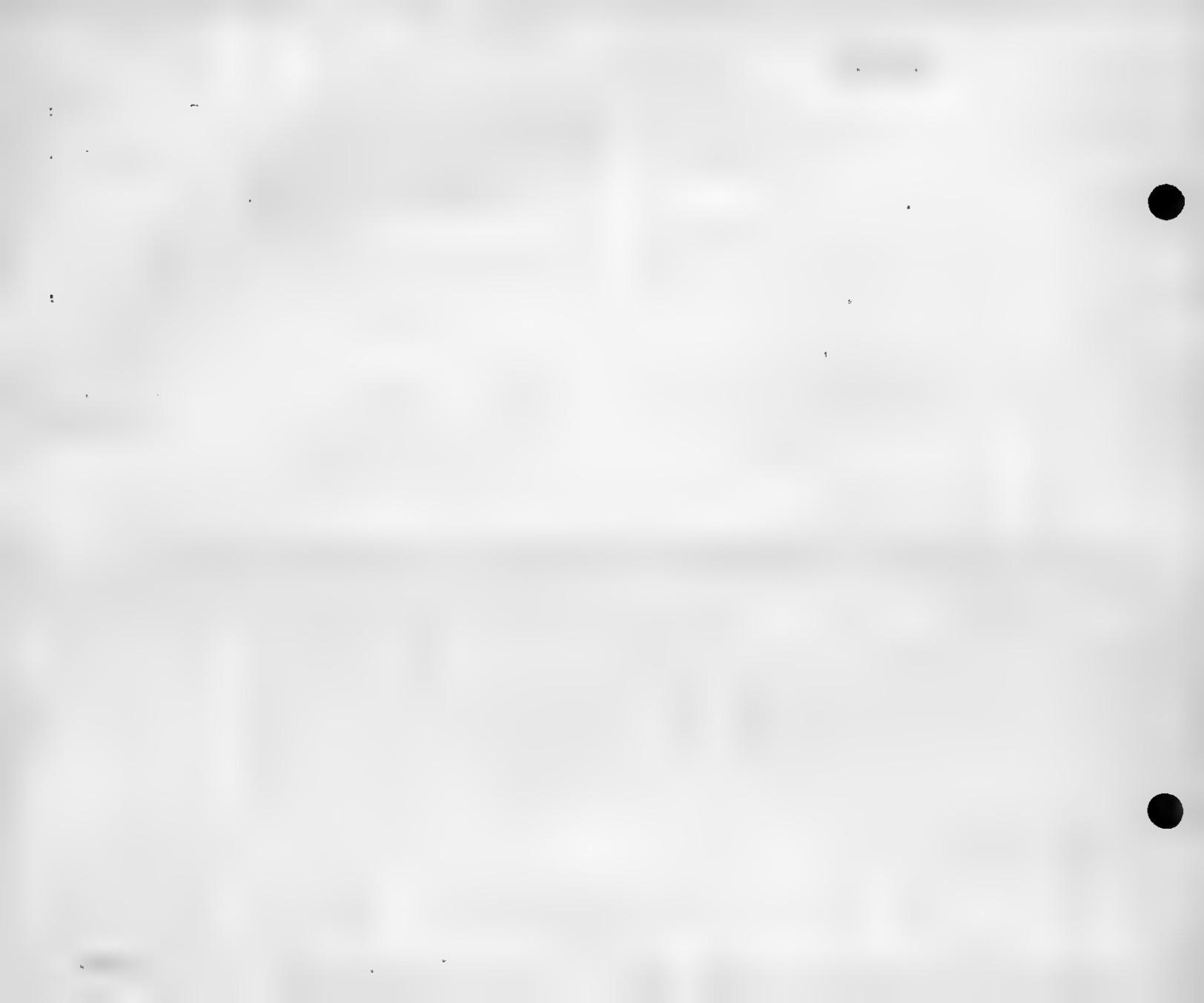
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05631	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2d. DATE OF DEATH Month Day Year			2b. HOUR Hour Min		
			SISTER Loyola HEALY			October 29 1969			10:45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday) 80 yrs.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
FEMALE		WHITE		7/4/88		80 yrs.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA, MD		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		MONTGOMERY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA, MD			SUBURBAN			TEACHER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
MONTGOMERY, MD			BETHESDA, MD			YES <input type="checkbox"/>			9600 FOREST RD.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Timothy			Margaret						McBREES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
			405			Consort Records			9600 Forest Rd.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral thrombosis?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 da											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> 4 yrs											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary artery disease.</u>											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
<input type="checkbox"/> ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 1949, 19, to 10/29, 1969, that (I) (we) last saw the deceased alive on 4/28/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Bernard J Walsh, M.D.			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10/29/69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS 1800 Eye St N.Y. - D.C.								
23a. BLR A. CREMATION, BURIAL		23b. DATE 5-2-69		23c. NAME OF CEMETERY OR CREMATORIAL Mt Olivet Cemetery			23d. LOCATION (City or Town) Washington, D. C.			(County) (State)	
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR DA MAY 5 1969			25b. REGISTRAR'S SIGNATURE Robert A Pumphrey				
VR A15 (4) 45M - 1/69											



05637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First Thomas	Middle Anthony	Last Hessian	2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/>	Month 4-	Day 9	Year 69	2b. HOUR 5:35M	
3 SEX M	4 RACE W	5. DATE OF BIRTH 2-27-28	6 AGE (In years 41 YRS)	7 IF UNDER MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 4 Day Year 1969			2d. HOUR 5:35M	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Counselor			12b. KIND OF BUSINESS OR INDUSTRY Employment agency		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Montgomery		13d. INS-DE CITY LN 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 816 Easley St.				
14. FATHER'S NAME William P Hessian		15. MOTHER'S MAIDEN NAME Mary Hughes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 1948 to 1952 216 24 7522		17. INFORMANT Dora J Hessian			ADDRESS Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive cerebral vascular hemorrhage									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Accidental head injury									1 day	
DUE TO, OR AS A CONSEQUENCE OF (c) Fell in home									-	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4-8 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Fall at home						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No 816 Easley St. Hyattsville, Md.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Roger		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Honolulu Honolulu Hawaii								22b. DATE SIGNED 4-8-69
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 14, 1969		23c. NAME OF CEMETERY OR CREMATORIUM Punch Bowl National		23d. LOCATION (City or Town) Honolulu		(County) Honolulu	(State) Hawaii	
24. FUNERAL DIRECTOR		ADDRESS Francis Gasch's Sons Hyattsville Md.			25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05638

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05633

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year	2b. HOUR 1 33 M				
Vernon	S	Hill	4/7 1969								
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 IF UNDER MONTHS	8 IF UNDER 24 HRS DAYS	9 DEATH MATED HOURS	10 DEATH MATED MIN				
Male	Negro	7/14/1898	70 YRS								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH					
Maryland		USA				Montgomery Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Suburban Hosp								
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER				
Md			Montgomery				713 Douglas Ave				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
Vernon					Hill	Bessie			Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT	ADDRESS				
no						Wife	Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> Approximate interval between onset and death 1/2 hr.											
DUE TO, OR AS A CONSEQUENCE OF Conditons if any, which gave rise to immediate cause (a), stating the underlying cause 4124 (b) <u>Cardio-Vascular Disease -</u> years.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			2d. AUTOPSY?					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John S. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED APR 11 1969			
23d. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 4-10-69			23c. NAME OF CEMETERY OR CREMATORIUM Lincoln Park Cem.		23d. LOCATION (City or Town) Rockville		(County) Montg	(State) Md.
BURIAL											
24. FUNERAL DIRECTOR			ADDRESS Robert L. Snowden Rockville, Md.			25a. RECD BY REGISTRAR APR 14 1969		25b. REG STRR'S SIGNATURE Charles J. ...			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05639

CERTIFICATE OF DEATH

05634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Hannah</i>	Middle	Last <i>Hoffer</i>	2a. DATE OF DEATH Month 4	Day 6	Year 1969	2b. HOUR 2:50PM
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH <i>Jan 30, 1887</i>	6. AGE (in years last birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County Md.</i>				
10. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Montgomery Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE C. T. Y. LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>8600 16th St. Silver Spring</i>			
14. FATHER'S NAME First <i>LOUIS</i>	Middle <i></i>	Last <i>GOLD</i>	15. MOTHER'S MAIDEN NAME First <i>Unknown</i>	Middle <i></i>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO <i>231-26-5833-A</i>	17. INFORMANT <i>Dr. Herbert M. Hoffer</i>	Address <i>8309 Raymond Lane Potomac, Maryland</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 HOURS</i>			
41 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>CORONARY ATHEROSCLEROSIS</i>				4-5 YRS			
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>POST-OPERATIVE FRACTURE RIGHT HIP, OLD MYOCARDIAL INFARCTION</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At Home, Farm, Street, Factory Office Building, Etc.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (This hospital) attended the deceased from <i>FEB</i> , 19 <i>67</i> , to <i>APRIL 6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>APRIL 6</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward A. Beeman M.D.</i>				22c. DATE SIGNED <i>APRIL 6, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>EDWARD A. BEEMAN</i>	22e. ADDRESS <i>1815 SPRING ST. SILVER SPRING, MD 20910</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>April 8, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Lawn Cemetery</i>	23d. LOCATION (City or Town) <i>Norfolk</i>	(County) <i>Virginia</i>	(State)		
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>	ADDRESS <i>232 Carroll</i>	25a. REEDDY REGISTRATION <i>APR 9 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>				
Hebrew Memorial Funeral Home St., N.W. Wash., D.C.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

05640

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05635

1. DECEASED NAME (Type or print)	First <i>William</i>	Middle <i>Hoffman</i>	Last <i></i>	2a. DATE OF DEATH Month <i>April</i>	Day <i>4</i>	Year <i>1969</i>	2b. HOUR <i>8:30 A.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>Nov. 3, 1891</i>	6. AGE (In years last birthday) <i>77</i>	7. IF UNDER 1 YEAR MONTHS <i></i>		8. IF UNDER 24 HRS MONTHS <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>				
10. CITY OR TOWN OF DEATH <i>Wheaton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>12404 Livingston St.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Welder (Retail)</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>New Jersey</i>	13b. COUNTY <i>Carden</i>	13c. CITY OR TOWN <i>Carden</i>	13d. INSIDE CITY LIMIT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>827 Morgan Street</i>			
14. FATHER'S NAME First <i>unknown</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>unknown</i>	Middle <i></i>	Last <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>150-10-19097</i>	17. INFORMANT <i>Mrs. Elizabeth Thompson</i>	Address <i>Wheaton, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> <i>years</i> (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb. 23, 1969</i> , to <i>April 4, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 4, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>John J. Curry, M.D.</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/4/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>John J. Curry</i>		22e. ADDRESS <i>9801 Georgia Ave., Silver Spring, Md.</i>					
23a. BUR. A. CREMAT. ON, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Apr. 8, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>New St. Mary's Cemetery</i>	23d. LOCATION (City or Town) <i>Bellmar</i>	(County) <i>New Jersey</i> (State)		
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc. Silver Spring, Md.</i>		25a. ADDRESS <i>8434 Georgia Avenue</i>		25a. RECD BY REGISTRAR <i>APR 11 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Warren E. Pumphrey, Inc.</i>		



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH			05636		
1	1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			Month	Doy	Year	2b. HOUR		
	Karen			B	Holman		April 11, 1969						11:30 AM		
3	SEX	4 RACE			5. DATE OF BIRTH			6. AGE (In years last b'day)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
	Female	Caucasian			11/16/1886			82 YRS.							
7a	BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH				
	South Dakota	U.S.						<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Montgomery County				
10	CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY							
	Silver Spring, Maryland	Colonial Villa Nursing School			Teacher						Md				
13a	US/JAL RESIDENCE (Where deceased lived, if institution admission) STATE	13c. C.TY OR TOWN			13d. INSIDE CITY L.M.TSP			13e. STREET AND NUMBER							
	Maryland	Montgomery			Silver Spring			YES <input type="checkbox"/>	NO <input type="checkbox"/>	6411-Silage Ave.					
14	FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last					
	John E. BRENNER				Elizabeth WALTER										
16a	WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO			17. INFORMANT			Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		494-30-4544			William B Holman			5441 Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>4124</u> <u>Cerebral vascular thrombosis</u>															
DUE TO OR AS A CONSEQUENCE OF															
(b) <u>Generalized arteriosclerotic cardiovascular disease</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<u>Probable undiagnosed metastatic carcinoma</u>															
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
		-						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
		While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BLDG, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>31 March 1967</u> , to <u>11 April 1969</u> , that (I) (we) last saw the deceased alive on <u>9 April 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Ernest E Harmon MD</u>															
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS													
		Ernest E Harmon MD 9301 Colesville Rd Silver Spring													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town) (County)			(State)				
Burial		April 16, 1969			Norwegian			Mobridge, South Dakota							
24. FUNERAL DIRECTOR		P. J. Smith			ADDRESS			25a. RECEIVED BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE				
		Warner E. Pumphrey Inc.			8434 9th Ave. Silver Spring, Md.			APR 17 1969			Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05642

05637

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First LORRAINE	Middle B	Last HOMER	2a. DATE OF DEATH Month April	Day 26	Year 1969	2b. HOUR 5-25 AM	
3 SEX Female	4 RACE White			5. DATE OF BIRTH August 29, 1908	6 AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR MONTHS 5	IF UNDER 24 HRS. DAYS 20	2b. HOUR HOURS 5	
7a BIRTHPLACE (State or foreign country) Washington D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH MONTGOMERY				
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY NIH				
13a USUAL RESIDENCE (Where deceased lived, if institution Resdence before admission) STATE MARYLAND	13b COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 5818 GreenTree Rd.					
14 FATHER'S NAME First JESSE	Middle LEE	Last Bunch	15 MOTHER'S MAIDEN NAME First Middle MARY ALICE	Lost					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b SOCIAL SECURITY NO. 577-48-4416	17 INFORMANT Charles H. HOMER	Address Sgt.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. coma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma ovary									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 31, 1964 , to APRIL 26, 1969 , that (I) (we) last saw the deceased alive on APRIL 25, 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edgar H. Levin MD	DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4/26/69						
22d. PHYSICIAN'S NAME (Type) EDGAR H. LEVIN	22e. ADDRESS 8218 Wisconsin Ave., Bethesda								
23a. BURIAL, CREMATION METHOD (Specify) CREMATION	23b. DATE 4-29-69	23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek	23d. LOCATION (City or Town) Washington, D.C.	23e. (Country) 	(State) 				
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557-Wisconsin Ave., Bethesda, Md.	25a. REC'D BY REGISTRAR DATE MAY 5 1969	25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05638

05643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of her death.

1 DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR 3:25 p.m.	
		MICHAEL JOSEPH HORKAN			April 8, 1969		
3 SEX	4. RACE	White	5 DATE OF BIRTH	January 16, 1889	6 AGE (in years last birthday) 80 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) England	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mail Clerk	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8112 Tahona Dr.			
14 FATHER'S NAME Michael Horkan	First	Middle	Lost	15 MOTHER'S MAIDEN NAME Mary Griffin	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown None	16b. SOCIA. SECURITY NO	17. INFORMANT Hospital Chart	Address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Bronchopneumonia + Emphysema Pulmonary		Coronary occlusion Coronary Arteriosclerosis Arterosclerosis generalized -					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> , 19 <u>69</u> , to <u>4/8/69</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED Aug 69	
22d. PHYSICIAN'S NAME (Type) Thomas P. Fogarty	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-12-69	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) Silver Spring, Maryland	(County)	(State)		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS	ADDRESS 1000 University Blvd. East, Silver Spring, Md.	25a. REC'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE James J. Fogarty				
VR A15 45M - 1X6							



FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form A.M.T. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05644

05639

1. DECEASED NAME (Type or Print)	First John	Middle H.	Last Hossman	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 4	Day 4	Year 1969	2b HOUR 20 M			
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH 3/12/1875	6 AGE (In years at time of death) 94 yrs	7 IF UNDER MONTHS <input type="checkbox"/>	YEAR 0	IF UNDER 24 HRS. HOURS <input type="checkbox"/>	MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month 4	Day 04	Year 1969	2d HOUR 9:20 M
7a BIRTHPLACE (State or foreign country) Wisconsin	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital University Nur. Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Montg.	13c. CITY OR TOWN Sil. Spr.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 1701 Sherwood Rd.							
14. FATHER'S NAME Johann	Middle Hossman	Last 	15. MOTHER'S MAIDEN NAME Wilhelmina	Middle 	Last ?						
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16b SOCIAL SECURITY NO. Spanish Amer. 393-03-9065	17. INFORMANT Mrs. Ruth Oass, 1701 Sherwood Rd.	ADDRESS Silver Spring, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Heart Disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) Belden R. Reap, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED April 4, 1969	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE April 5, 1969		23c NAME OF CEMETERY OR Crematory St. Pauls Lutheran Cemetery		23d. LOCATION (City or Town) Menomonie, Wisconsin		(County)		(State)	
24. FUNERAL DIRECTOR Paul J. Smith & Sons Inc.		ADDRESS 8434 Georgia Avenue		25a REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					
Warner E. Humphrey, Inc.		Silver Spring, Md.									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05640

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Mary	Middle M.	Last Hottinger	2a. DATE OF DEATH Month April	Day 13	Year 1969	2b. HOUR 10 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 22, 1883	6. AGE (In years last birthday) 85		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS GAYS 0	HOURS 00	MIN 00
7a. BIRTHPLACE (State or foreign country) West Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Germantown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Marylander			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Boyd's	13d. INSIDE CITY LIMITS? YES	<input type="checkbox"/> NO	13e. STREET AND NUMBER Rt. #1 Box 265A	Md.		
14. FATHER'S NAME Frederick Lowry		First	Middle	Last	15. MOTHER'S MAIDEN NAME Frances Emily Lowry		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16b. SOCIAL SECURITY NO -		17. INFORMANT Mr. Lester Hottinger		Address Washington Grove, Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Parkinson's Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 years		
342 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis						Years		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cystitis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State	
22o. I certify that (I) (his hospital) attended the deceased from 12 Aug., 1960 , to 12 April, 1969 , that (I) (we) last saw the deceased alive on 1 Apr. 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b. SIGNATURE Gordon Murdoch Smith, M.D.		22c. DEGREE Degree		ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED 13 Apr. '69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Barnesville, Maryland 20703								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-16-69		23c. NAME OF CEMETERY OR CREMATORIAL St. Lukes		23d. LOCATION (City or Town) Redland		(Country) Mont.	(State) Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.		25a. RECEIVED BY REGISTRAR DATE APR 18 1969		25b. DEATH REGISTRAR'S SIGNATURE Charles J. Judge				
VR. A15 45M										



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1
05641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First <i>Martin</i>	Middle <i>John</i>	Last <i>Hudtloff</i>	2a. DATE OF DEATH Month <i>April</i>	Day <i>6</i>	Year <i>1969</i>	2b. HOUR Min. <i>10 A.M.</i>
3. SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>11/10/02</i>		6. AGE (in years last birthday) <i>66</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Montana</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Saburo</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Kelvin</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Mont</i>	13b. COUNTY <i>Kensington</i>	13c. CITY OR TOWN <i>Kensington</i>	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>7916 Maryland Lane</i>			
14. FATHER'S NAME First <i>MARTIN</i>	Middle <i>DAVID</i>	Last <i>HUDTLOFF</i>	15. MOTHER'S MAIDEN NAME First <i>SILIA</i>	Middle <i>-</i>	Last <i>DETLOFF</i>	Address <i>Arlington Va</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i>	16b. SOCIAL SECURITY NO <i>317-44-0247</i>	17. INFORMANT <i>Son</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>cardiovascular collapse</i> <i>acute myocardial infarction</i> <i>artery disease</i> <i>10 yrs</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>acute myocardial infarction</i> <i>artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>arrhythmia</i> <i>ventricular fibrillation</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i> <i>ventral</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>artery disease</i> <i>10 yrs</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>arrhythmia</i> <i>ventricular fibrillation</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (1) (this hospital) attended the deceased from <i>1962</i> , to <i>1969</i> , that (1) (we) last saw the deceased alive on <i>March 27, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.R. Hermanbaut MD</i>	DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>4/6/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>W.R. Hermanbaut</i>	22e. ADDRESS <i>1125 Rockville Pike Rockville</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BU.31742</i>	23b. DATE <i>4/9/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>ARLINGTON NAT. CEM. WASHINGTON D.C.</i>	23d. LOCATION (City or Town) <i>ARLINGTON</i>	(Country) <i>U.S.A.</i>	(State) <i>VA.</i>		
24. FUNERAL DIRECTOR <i>JOSEPH GRANLER'S SONS, 5130 WIS. AVE., N.W.</i>	25. DEED BY REGISTRAR DATE <i>APR 11 1969</i>		25. REGISTRAR'S SIGNATURE <i>Franklin George</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in **Y** (The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05647		CERTIFICATE OF DEATH						0564			
1. DECEASED NAME (Type or print)		First Kathryn	Middle Sadie	Lost Hunter	20. DATE OF DEATH Month April		20. DATE OF DEATH Year 1969	2b. HOAM 7:55 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1 December 1968		6. AGE (In years lost birthday) 4 yrs.		IF UNDER 1 YEAR MONTHS 4		IF UNDER 24 HRS. DAYS 23	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13c. CITY OR TOWN Athens		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 712 Wells Avenue					
14. FATHER'S NAME First Duane		Middle Hunter	Lost	15. MOTHER'S MAIDEN NAME First Norleene		Middle	Lost				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Bethesda, Maryland 20014		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Minutes					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brachycardia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypoplastic left heart syndrome DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION 4/23/69		19b. CONDITION FOR WHICH OPERATION PERFORMED Atresia of Aortic Arch		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 14 April 1969 to 24 April 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 24 April 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>Michael A. Berman, MD</i>		22c. DATE SIGNED 24 April 1969									
22d. PHYSICIAN'S NAME (Type) Michael A. Berman, MD.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-28-69		23c. NAME OF CEMETERY OR CREMATORIAL D.C.		23d. LOCATION (City or Town) Athens, Pa.		(County)		(State)	
24. FUNERAL DIRECTOR WW Chambers Co		ADDRESS 1400 e. hepner st. d.c.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 28 1969			

52 - 240

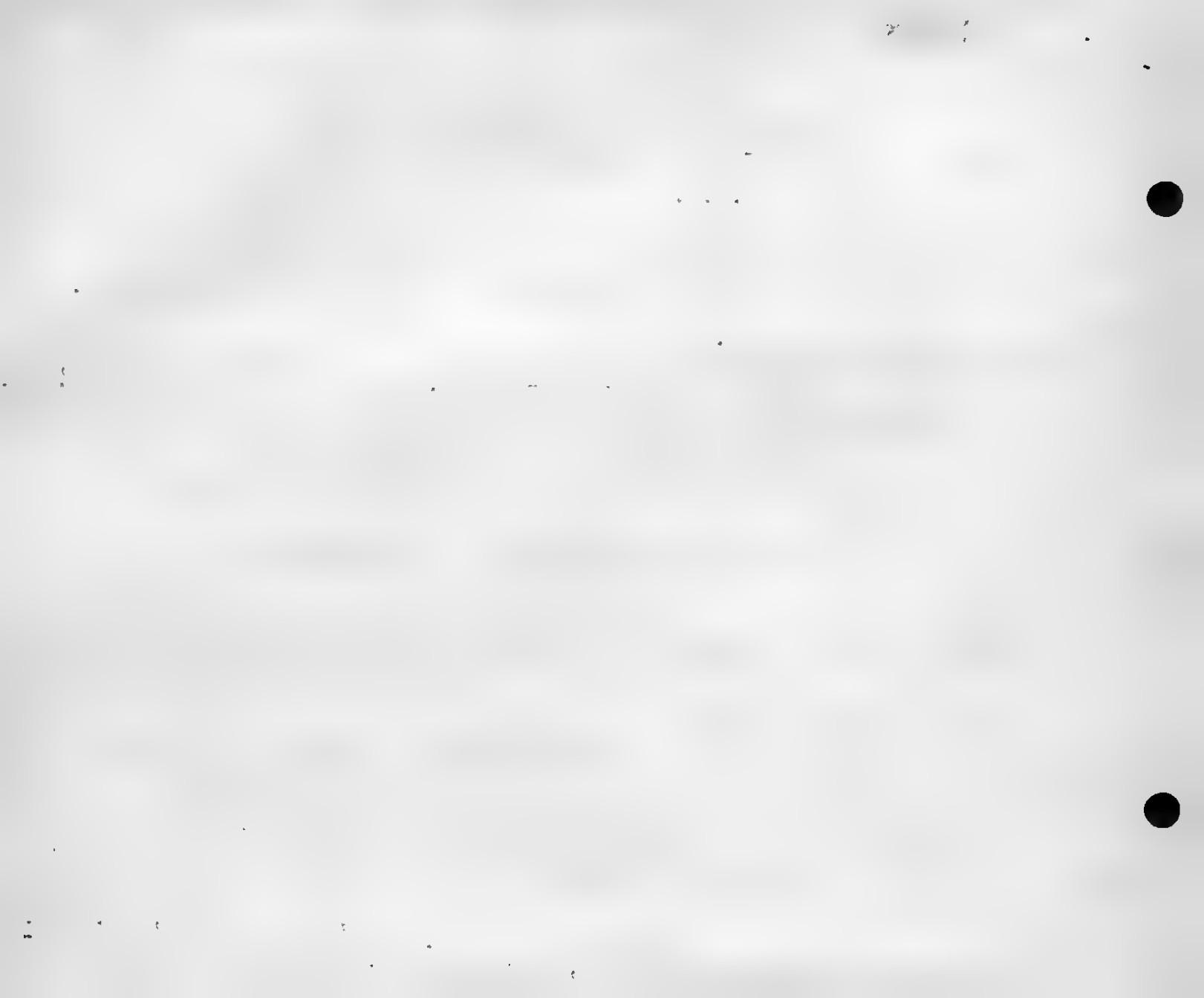
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1000. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05643

1. DECEASED NAME (Type or Print)	First <i>Lucy Margaret</i>	Middle <i>Osenann</i>	Last <i>Osenann</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 4	Day 8	Year 69	2b. HOUR 6:30 A.M.				
3 SEX <input checked="" type="checkbox"/> F	4 RACE <input checked="" type="checkbox"/> Caucasian	5 DATE OF BIRTH 3-06-89	6 AGE (in years) 80 YRS	7 IF UNDER 7 YEARS MONTHS 0	8 IF UNDER 24 HRS DAYS 0	9 HOURS 0	10 MIN. 0	2c DATE PRONOUNCED DEAD Month 4	Day 8	Year 69	2d HOUR 6:30 A.M.	
7a BIRTHPLACE (State or foreign country) Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery									
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Hospt	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker	12b. K IND OF BUSINESS OR INDUSTRY ***									
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4977 Battery Lane.								
14. FATHER'S NAME First Horace	Middle P.	Last Smith	15. MOTHER'S MAIDEN NAME First Mary	Middle Elsea	Last Elsea							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No	16b. SOCIAL SECURITY NO (If yes give rank and dates of service.) 579-12-7712-D	17. INFORMANT Mrs. Valentine McInteer, Beth. Md.	4853 Croppell Avenue									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute Coronary Insufficiency											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
22b. DATE SIGNED <i>April 8, 1969</i>												
ACTUAL SIGNATURE <i>Belder R. Reap</i> M.D.												
EXAMINER'S NAME (Type) <i>BELDER R. REAP M.D.</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-11-69	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery, Bladensburg	23d. LOCATION (City or Town) Pr. Geo.	(County)	(State)							
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY,	25a. ADDRESS 7557 Wisconsin Ave.	25b. REC'D BY REGISTRAR APR 15 1969	25c. SIGNATURE <i>Robert A. Pumphrey</i>									
VR A15ME (5) 10M REV 1/68												



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05649

Item2a FilmG12 5/7/69 kk

CERTIFICATE OF DEATH

05644

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send 2 direct, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. DECEASED NAME (Type or print)	First ERNEST	Middle	Lost JACKSON	2a. DATE OF DEATH Month April	2b. HOUR Doy 10 69	
3. SEX Male	4 RACE Colored	S. DATE OF BIRTH 6-6-1900	6. AGE (In years lost birthday) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Junk dealer	12b. KIND OF BUSINESS OR INDUSTRY Md.			
3a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Washington, D.C.	13c. CITY OR TOWN D.C.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2526 8th Street, N.W.			
14. FATHER'S NAME First John	Middle Jackson	15. MOTHER'S MAIDEN NAME First Middle Clara Terry				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, no, or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Sister	Address Mrs. Pearl Coleman-4574 Eads St., N.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 150 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Carinomatosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown		
DUE TO, OR AS A CONSEQUENCE OF (b) Carinoma of esophagus						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) at work			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 6 1969 , to Apr 10 1969 , that (I) (we) last saw the deceased alive on April 5 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Henry G. Hadley		DEGREE PHYS	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4-11-69
22d. PHYSICIAN'S NAME (Type) Henry G. Hadley, M. D.		22e. ADDRESS 4601 Nichols Avenue, S.W., Wash. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/16/69	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park	23d. LOCATION (City or Town) Maryland	(County)	(State)
24. FUNERAL DIRECTOR John J. Stewart Jr.		ADDRESS Stewart Funeral Home-4001 Benning Road, N.E.	25a. RECEIVED BY REGISTRAR APR 14 1969	25b. REGISTRAR'S SIGNATURE John J. Stewart Jr.		
VR A15 45M - 1						



Item 6 FilmGL12 5/6/69 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05650

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05645

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b HOUR
Male white	Henry	E.	Jones	<input checked="" type="checkbox"/>	April	26	1969	4 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	F UNDER 24 HRS			
Male white		5/1/41	54 yrs	MONTHS	DAYS	HOURS	MIN	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH				
Bethesda	U.S.A.			Maryland				
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done or (if most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	Suburban Hospital			Suburban Hospital	Private			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER				
Md.	Mont.	Bethesda	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7th & 2-				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Henry			Jones	Freda			Eshbaugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT			ADDRESS			
No	22-40-1533	Gertrude Jones			115 - 1st			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY								
IMMEDIATE CAUSE (a) ACUTE FIBRINO-PURULENT PERITINITIS								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) RUPTURED GANGRENOUS APPENDIX								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
					<input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>John G Ball</u>								
EXAMINER'S NAME (Type) John G Ball								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE May 1, 1969	23c NAME OF CEMETERY OR CREMATORIUM Davis Memorial Cemetery		23d. LOCATION (City or Town) Cumberland, Allegany, Md.		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>		
VR ATSMF (5) TOM REV 1/68								



TO HOSPITAL OR ATTENDING PHYSICIAN

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05646

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
Laura Aurelia Johnson						4 10 1969	12:10PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
F	Negro	2-10-1903			66 yrs.			
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
GEORGIA	USA				MONTGOMERY			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
WHEATON	U. N. HOME			R.N.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
D.C.			YES <input checked="" type="checkbox"/>	1339 Otis Place N.W. Wash. DC				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
	James		Johnson	Sarah			Buggs	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.			17. INFORMANT	Address			
Yes, no, or unknown)	577-12-5163			Miss Cl. Johnson	Same as pt's			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular accident APPROXIMATE INTERVAL Conditions if any, which gave rise to immediate cause (a) Generalized arteriosclerosis ONSET AND DEATH stating the underlying cause (b) chronic last. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal insufficiency								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
				315	1969	1110	1969	
22a. I certify that (I) (this hospital) attended the deceased from 3/5 , 1969, to 11/10 , 1969, that (I) (we) last saw the deceased alive on 3/5 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.								
22b. SIGNATURE David S. Stewart, M.D.		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 4/10/69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/15/69	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park			23d. LOCATION (City or Town) Maryland	(County)	(State)
Burial								
24. FUNERAL DIRECTOR		ADDRESS Stewart Funeral Home, Inc.			25a. REC'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE Charles J. Steward		
Stewart		Rte. 1, Box 1001, Lanning Rd., N.E.						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and 7, from this certificate and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)			First LLOYD	Middle EDWARD	Last JONES	2o. DATE OF DEATH Month APRIL	Doy 12	Year 1969	2b. HOUR 1:26 PM	
3. SEX MALE			4 RACE CAUC	5. DATE OF BIRTH 14 SEPT. 1946			6. AGE (In years lost birthday) 22 YRS.			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETHESDA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) USN			12b. KIND OF BUSINESS OR INDUSTRY USN	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2149 HAWKINS PT. RD.		
14. FATHER'S NAME First LLOYD			Middle (NMN)	Last JONES	15. MOTHER'S MAIDEN NAME First ALICE			Middle PAGE	Last BELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> Unknown			16b. SOCIAL SECURITY NO. 17MARGO PRESE			17. INFORMANT MRS. L. JONES			Address BALTIMORE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			MULT. FRAGMENT WOUNDS OF LEG AND CHEST WITH PERFORATION OF COLON, SMALL BOWEL AND LIVER						APPROXIMATE INTERVAL BETWEEN DNSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) BATTLE CASUALTY IN REPUBLIC OF VIETNAM				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. LOCATION Street or RFD No. City or Town County State				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 09 MAR 1969 , to 12 APRIL 1969 , that <input type="checkbox"/> (we) last saw the deceased alive on 12 APRIL 1969 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.										
22b. SIGNATURE <i>Donald K. Roeder, MC</i>			22c. DEGREE LCDR			ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED 13 April 1969	
22e. PHYSICIAN'S NAME (Type) LCDR DONALD K. ROEDER, MC, USN			22f. ADDRESS Naval Hospital BETHESDA, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 17 APRIL 1969			23c. NAME OF CEMETERY OR CREMATORIAL McCULLY'S CEDAR Hill			23d. LOCATION (City or Town) (County) (State) BROOKLYN PARK MD.	
24. FUNERAL DIRECTOR W.W. Chambers 1400 cloh st nw			ADDRESS Akab. DC			25a. RECD BY REGISTRAR APR 17 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in at the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05653

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05648

1. DECEASED NAME (Type or print)		First RUTH	Middle LEWIS	Last JONES	2d DATE OF DEATH Month 11 Day 12 Year 69	2b. HOUR 11:05PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1-23-11			6. AGE (In years last birthday) 58	If Under 1 Year Months 0 Days 0 Hours 0 Min 0	
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager & Owner		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY J.M.T.S. <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3600 Gleneagles Drive		
14. FATHER'S NAME First Middle Last Chester V. Lewis		15. MOTHER'S MAIDEN NAME First Middle Last Georgia			16b. KIND OF BUSINESS OR INDUSTRY Happy Time To		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 579 48 3729		17. INFORMANT Admission Rec'd., Montgomery Gen. Hospital, Olney			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF Adenocarcinoma of Lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 wks		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION 4/2/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of lung.		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> , 19 <u>67</u> , to <u>4/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>69</u> , and that in (my) (<u>we</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death.							
22b. SIGNATURE Richard A. Yates, MD		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4/12/69	
22d. PHYSICIAN'S NAME (Type) Richard A. Yates, MD		22e. ADDRESS OLNEY, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 4/16/69	23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove		23d. LOCATION (City or Town) Lynn, Massachusetts	(County)	(State)
24. FUNERAL DIRECTOR Joseph Gawler's Son, 5130 Wisconsin Av., NW Wash. D.C.		ADDRESS		25a. REC'D. BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE joseph gawler		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05654

CERTIFICATE OF DEATH

05643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>Marilyn</i>	Middle <i>E</i>	Lost	2a. DATE OF DEATH 4 Month / Day 64 Year	2b. HOUR 12 P.M.
3. SEX <i>F</i>	RACE <i>W</i>	S. DATE OF BIRTH <i>9/3/30</i>	6. AGE (In years lost birthday) <i>38 yrs</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>13335 Fallall Dr.</i>	
14. FATHER'S NAME First <i>ABRAHAM</i>	Middle <i>- OKEAN</i>	15. MOTHER'S MARRIED NAME First <i>ANNA</i>	Middle <i>- SEIGEL</i>	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>	17. INFORMANT <i>ALVIN KRIST</i>	Address <i>(same as 13a)</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of heart with</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>generalized metastasis</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>April 67</i> <i>6 months</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (This hospital) attended the deceased from <i>Aug 17, 1968</i> , to <i>1 April, 1969</i> , that (I) (we) last saw the deceased alive on <i>1 April 1969</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Walter E. Goode MD</i>	DEGREE ATTENDING PHYS	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>4/1/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>WALTER E. GOODE MD</i>	22e. ADDRESS <i>2309 Shorefield Rd Wheaton MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4-2-1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Montgomery Cemetery</i>	23d. LOCATION (City or Town) <i>Rockville, Md. MD</i>	(County) <i>Montgomery Co. MD</i>	(State) <i>MD</i>
24. FUNERAL DIRECTOR <i>Charles J. Gause</i>	ADDRESS <i>Concourse Woods Home 4217 9th St. NW</i>	25a. REC'D BY REGISTRAR <i>Charles J. Gause</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Gause</i>		
30M. REV. 1-68	DATE APR 7 1969				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05650

05655

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. DECEASED NAME (Type or print)	First <i>Michael</i>	Middle	Last <i>Karelson</i>	20. DATE OF DEATH Month <i>4</i>	69 Year	2b. HOUR <i>8:30 AM</i>		
3. SEX <i>M</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>12/3/70</i>	6. AGE (In years last birthday) <i>78</i> YRS	FUNDER 1 YEAR MONTHS <i>1</i>	DAYS <i>0</i>	HOURS <i>8</i>	MIN <i>30</i>	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Hebrew Hills Nursing Home, Inspector Western Union</i>				
10. CITY OR TOWN OF DEATH <i>Wheaton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 9. street address) <i>Hebrew Hills Nursing Home, Inspector Western Union</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Inspector Western Union</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>	13b. CITY OR TOWN <i>Montgomery Rockville</i>	13c. INSIDE CITY OR TSP <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>1639 Jefferson St.</i>					
14. FATHER'S NAME First <i>Harris</i>	Middle <i>Karelson</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Rose</i>	Lost					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>101054768</i>	17. INFORMANT <i>Paul Karelson (son)</i>	Address <i>1030 Crane Rd., N.E. Atlanta, Georgia</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Arteriosclerotic heart disease</i> (c) <i>Reuler's syndrome</i>								
IMMEDIATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>10 yrs</i> <i>5-6 yrs</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Decreas. in food</i>								
19a. DATE OF OPERATION <i>12/10/67</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>None</i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>None</i>	21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1966</i> , to <i>Apr. 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>17 Apr. 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John David MD</i>	22c. DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. PHYSICIAN'S NAME (Type) <i>John David MD</i>	22e. ADDRESS <i>King David Memorial Garden</i>	22f. DATE SIGNED <i>17 Apr. 67</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>April 20, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>King David Memorial Garden</i>	23d. LOCATION (City or Town) <i>Falls Church, Virginia</i>	(County) <i>Falls Church, Virginia</i>	(State) <i>Virginia</i>			
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>	ADDRESS <i>232 Carroll St., N.W. Wash., D.C.</i>	25a. REC'D BY REGISTRAR <i>APR 22 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

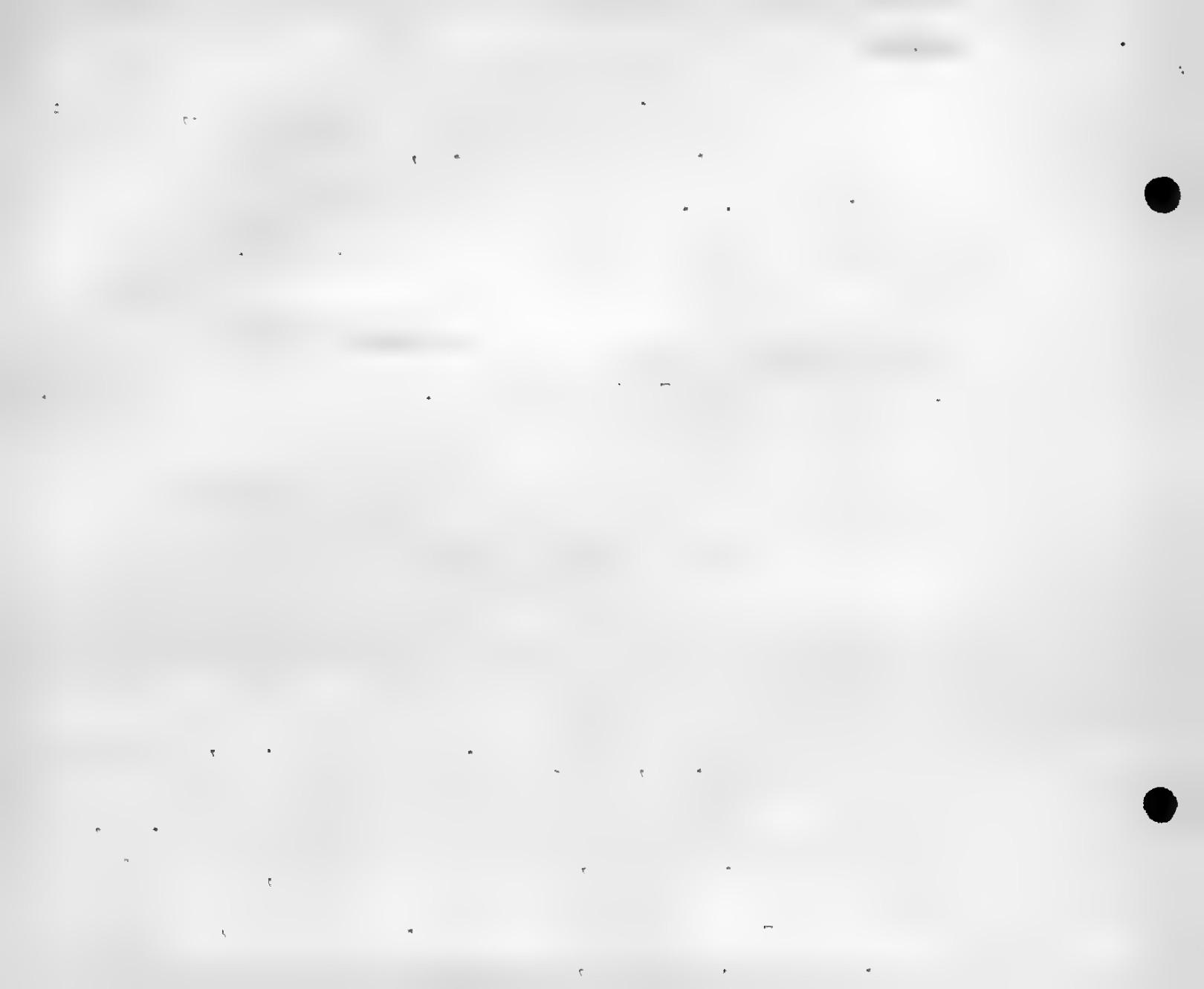
CERTIFICATE OF DEATH

05656

05651

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First JAMES	Middle A.	Last KELLY	2a. DATE OF DEATH Month April	Doy 21	Year 1969	2b. HOUR 4:00 M			
3 SEX Male		4 RACE Cauc.		5. DATE OF BIRTH Sept. 8, 1884		6. AGE (In years last birthday) 84			7. F UNDER 1 YEAR MONTHS 0	F UNDER 24 HRS DAYS 0	HOURS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6400 Landon Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Guard - Govt - Retired			12b. KIND OF BUSINESS OR INDUSTRY						
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INS. OF C. T. L. M. T. P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6400 Landon Lane				
14. FATHER'S NAME JAMES August Kelly				15. MOTHER'S MAIDEN NAME Catherine McCallion									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes.		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW I 216-46-0126		17. INFORMANT Daughter Irene E. Kelly		Address Same as Item 13.							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4123				Cardiac Arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Arteriosclerotic Heart Disease				DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease 8 years									
DUE TO, OR AS A CONSEQUENCE OF Generalized arteriosclerosis 10 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1962 , to Apr. 21, 1969 , that (I) (we) last saw the deceased alive on Mar. 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Thomas F. O'Connor MD</i>		22c. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22d. DATE SIGNED Apr. 21, 1969									
22d. PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR, MD		22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-24-69		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl Cem.		23d. LOCATION (City or Town) Arlington, Virginia		(County)		(State)			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS DA		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05657

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05652

1. DECEASED NAME (Type or Print)			First GEORGE	Middle R.	Lost KENNEBECK	2a DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 4	Day 29	Year 1969	2b HOUR M
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years at death/birth) 76 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month 4	Doy 29	Year 1969	2d HOUR 447	
Male	White	6/05/1892								
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most working life, even if retired) Dentist			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Sp.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 912 Hobbs Drive						
14. FATHER'S NAME George	Middle Kennebeck	15 MOTHER'S MAIDEN NAME Elizabeth								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 1918 (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO Army 1954 220-32-6566	17 INFORMANT Mrs. Elizabeth Kennebeck Sil. Sp., Md. (If yes give war or dates of service)								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 412 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease. (c)										
912 Hobbs Drive, Silver Spring, BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D. 22b. DATE SIGNED APRIL 29, 1969										
EXAMINER'S NAME (Type)		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.			23d LOCAT ON (City or Town) Burke Arlington, Virginia		(County)	(State)		
23a BURIAL, CREMAT ON REMOVAL (Specify) Burial		23b DATE May 2, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		23d LOCAT ON (City or Town) Burke Arlington, Virginia		(County)	(State)		
24 FUNERAL DIRECTOR P. J. Smith Warren E. Pumphrey, Jr. Silver Spring, Md.		ADDRESS 8434 Georgia Avenue			25a REC'D BY REGISTRAR DAV	25b REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05653
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED			Month	Day	Year	2b. HOUR
			Arthur	A.	Kilburg	<input checked="" type="checkbox"/>			4-23	19	69	10:50 A.M.
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR
male	white	5-7-05	5	MONTHS	DAYS	Hours	MIN.	4-23 Day			69	10:50 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Montgomery		
Iowa		USA										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			3029 Piney Br Rd S S Md			Superintendent			Building			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland			Montgomery			YES <input type="checkbox"/> NO <input type="checkbox"/>			8029 Piney Br Rd			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Peter					Kilburg	Mary					Puetz	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			577-07-1370			Mrs. Mildred E. Kilburg			Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Cardiorespiratory failure due to DUE TO, OR AS A CONSEQUENCE OF												
(b) _____ Barbiturate intoxication, apparently DUE TO, OR AS A CONSEQUENCE OF												
(c) _____ self-inflicted												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
MEDICAL CERTIFICATION	19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
	21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4-23 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased ingested overdose of barbiturate					
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State Silver Spring Montg. Md.					
	22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
	ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D. 22b. DATE SIGNED EXAMINER'S NAME (Type) <i>Belden R. Reap M.D.</i> 4/23/1969											
23a. BURIAL, CREMATION BURIAL (Specify)			23b. DATE 4-26-69			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.			
24. FUNERAL DIRECTOR Burial			Francis J. Collins ADDRESS 500 University Blvd. W., Silver Spring, Md.			25a. REC'D BY REGISTRAR APR 25 1969			25b. REGISTRAR'S SIGNATURE <i>Charles George</i>			
VR AT SME (S) 10M REV 1/68												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05659

05654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Frederick	Middle J.	Last King, Sr.	2a. DATE OF DEATH Month April	Year 1969	2b HOUR 7 26 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 19, 1907	6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Salesman		12b. KIND OF BUSINESS OR INDUSTRY Auto Tires						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 13014 Grenoble Dr.						
14. FATHER'S NAME First Albert		Middle King	Last 	IS MOTHER'S MAIDEN NAME First Anne	Middle 	Last Dyer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 074-10-8409		17. INFORMANT Nancy S. King		Address Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		<i>Coronary Occlusion</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day.</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		<i>Coronary Arteriosclerosis</i>		<i>Years</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive Heart Failure</i>												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. DATE OF OPERATION		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 12165		City or Town 4/5/69		County	State			
22a. I certify that (I) (this hospital) attended the deceased from 4/2/69 , to 4/5/69 , that (I) (we) last saw the deceased alive on 4/2/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John J. Curry MD</i>		22c. DEGREE MD		ATTENDING PHYS. MD.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/6/69			
22d. PHYSICIAN'S NAME (Type) John J. Curry, Md.		22e. ADDRESS 9801 Georgia Ave.										
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 9, 1969		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION (City or Town) Silver Spring		(County) Mont.	(State)			
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 500 University Blvd. W. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE APR 11 1969		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05660

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05655

1 DECEASED NAME (Type or print)	First <i>JAMES</i>	Middle <i>W</i>	Last <i>King</i>	2d. DATE OF DEATH Month <i>April</i>	Day <i>17</i>	Year <i>1969</i>	2b. HOUR <i>2:20 PM</i>
3 SEX <i>Male</i>	4 RACE <i>Negro</i>	S. DATE OF BIRTH <i>3/22/14</i>	6. AGE (In years last birthday) <i>55</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before of age) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>R# 2</i>			
14. FATHER'S NAME First <i>William</i>	Middle <i></i>	Last <i>King</i>	15. MOTHER'S MAIDEN NAME First <i>BERTHA</i>	Middle <i>?</i>	Last <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown <i>No</i>	16b. SOCIAL SECURITY NO (+ yes give war or dates of service)	17. INFORMANT <i>Laytonsville, Md.</i>	Address <i>Lillian Dorsey - (daughter)</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>yes</i> <i>yes</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>12 April 1968</i> , to <i>12 Apr 1968</i> , that (I) (we) last saw the deceased alive on <i>16 Apr 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John S. Davis</i>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>17 Apr 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>JOHN S. SAIA</i>		22e. ADDRESS <i>809 Rivers Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>4/22/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Brockliss Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Laytonsville, Montg. Md.</i>				
24. FUNERAL DIRECTOR <i>George R. Snodderly</i>	ADDRESS <i>Fochville Rd.</i>	25a. REC'D. BY REGISTRAR <i>E. 24 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>				



FOR STATE
HEALTH DEPT.

My delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form
PM3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05656

05661

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2d DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR	
ARTHUR	A.	KRUEHM		4-2	69				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN	2d HOUR	
M	CAUC	Dec 6 1889	79					4-2	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	Montgomery		
Md	USA								
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring	603 Rosemere Dr				Blacksmith				
13a USUAL RESIDENCE (Where deceased resided, if institution admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			603 Rosemere Rd	
Md	Md	Md	Silver Spring						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MIDDLE NAME	First	Middle	Last		
John Henry Kruehm				Mary Anne Sager					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)	16b. SOCIAL SECURITY NO (If yes give last or date of service)	17. INFORMANT	ADDRESS						
yes		Harriet Kruehm-Sager							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any (b) <u>of Bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary Artery Heart Disease.</u>									
19a. DATE OF OPERAT. ON	19b. CONDITION FOR WHICH OPERAT. ON WAS PERFORMED?				20. AUTOPSY?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE	Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED	
EXAMINER'S NAME (Type)	Belden R. Reap M.D.				Signature			APRIL 2, 1969	
23a. BURIAL, CREMATION & MOVA. (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCAT. ON (City or Town)	(County)	(State)				
Burial	4-4-69	Baltimore Natl	Baltimore	Md					
24. FUNERAL DIRECTOR	ADDRESS				25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE			
Conradian Funeral Home Laurel					APR 14 1969	Charles Judge			
VR A15ME (5) 10M REV 1/68									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

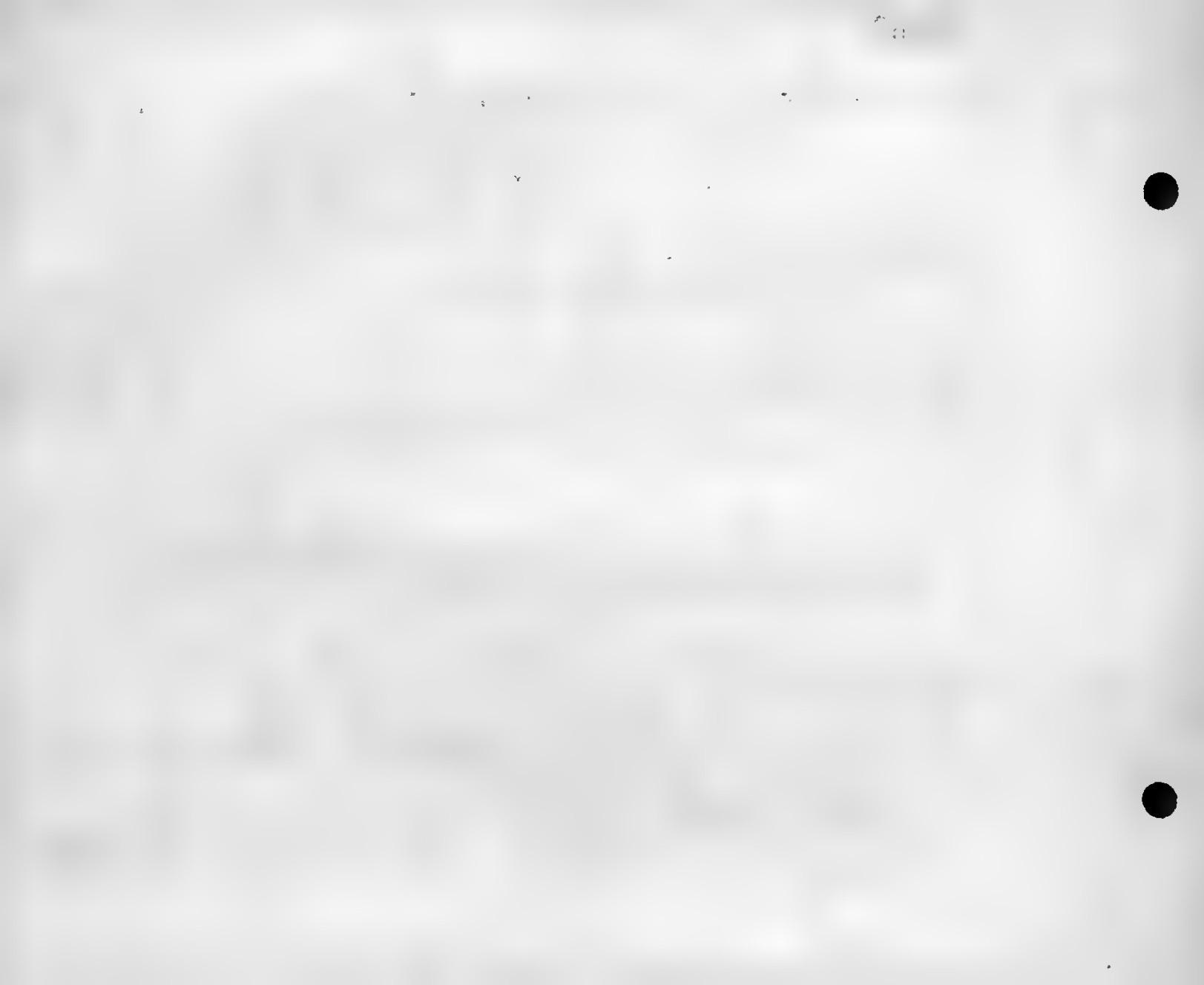
1 05662

05657

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	Middle Name	Date of Birth	2a. DATE OF DEATH	2b. HOUR	
SOL	Stanley	2000000000	4 Month 30 Day 69 Year	4:30 P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
M	Caus.	11-17-1898	70 yrs.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
N.Y.	USA		Montgomery		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Wheaton	Univ. Nurs. Home	Builder			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY L MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md. Montgomery	Silver Spring		9302 Piney Branch Rd.		
14 FATHER'S NAME	First Middle Last	15 MOTHER'S MAIDEN NAME	First Middle Last		
Aaron	Lazarus	Sarah	Samuelson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	16b. SOCIA. SECURITY NO.	17 INFORMANT	Address		
WW 2	217-18-5872	Mrs. Frances M. Lazarus	9302 Piney Branch Road, S.S. No.		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, LUL DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1(a) BULLOUS EMPHYSEMA, CORONARY ARTERY DIS.					
18. MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	19				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>4/17/69</u> , and that in (By) (his) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.	<u>July 1968</u> to <u>4/30/69</u> , that (I) (we) last				
22b. SIGNATURE <u>David Goldensberg MD</u>	DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <u>4/30/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u>	22e. ADDRESS <u>4801 Georgia, Silver Spring, MD</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE May 1, 1969	23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden	23d. LOCATION (City or Town) Falls Church, Virginia	(County)	(State)
24. FUNERAL DIRECTOR Donald M. Stein	ADDRESS 232 Carroll	25a. REC'D BY REGISTRAR MAY 5 1969	25b. REGISTRAR'S SIGNATURE <u>Charles J. Geiger</u>		
Hebrew Memorial Funeral Home St., N.W. Wash., D.C.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05663 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 5 Filed 5/12 5/169 kk

CERTIFICATE OF DEATH

05658

1. DECEASED NAME (Type or print)	First <i>Mary</i>	Middle <i>L.</i>	Last <i>Lee</i>	2a. DATE OF DEATH Month <i>4</i>	Day <i>24</i>	Year <i>1969</i>	2b. HOUR <i>5:00 pm</i>	
3. SEX <i>Female</i>	4. RACE <i>Negroid</i>	5. DATE OF BIRTH <i>1887</i>	Feb. 22, 1886	6. AGE (in years last birthday) <i>82</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery County</i>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>retired</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>203 Martins Lane</i>				
14. FATHER'S NAME First <i>William H. Lee</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Louise Washington</i>	Middle <i></i>	Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>	16b. SOCIAL SECURITY NO <i>577-05-2221</i>	17. INFORMANT <i>Adele L/ White</i>	Address <i>6425 14th St., N.W. D.C.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
41d5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour AM <input type="checkbox"/> 10 <input checked="" type="checkbox"/> 11 <input type="checkbox"/> 12 PM <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 Month Day Year <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input type="checkbox"/> 34 <input type="checkbox"/> 35 <input type="checkbox"/> 36 <input type="checkbox"/> 37 <input type="checkbox"/> 38 <input type="checkbox"/> 39 <input type="checkbox"/> 40 <input type="checkbox"/> 41 <input type="checkbox"/> 42 <input type="checkbox"/> 43 <input type="checkbox"/> 44 <input type="checkbox"/> 45 <input type="checkbox"/> 46 <input type="checkbox"/> 47 <input type="checkbox"/> 48 <input type="checkbox"/> 49 <input type="checkbox"/> 50 <input type="checkbox"/> 51 <input type="checkbox"/> 52 <input type="checkbox"/> 53 <input type="checkbox"/> 54 <input type="checkbox"/> 55 <input type="checkbox"/> 56 <input type="checkbox"/> 57 <input type="checkbox"/> 58 <input type="checkbox"/> 59 <input type="checkbox"/> 60 <input type="checkbox"/> 61 <input type="checkbox"/> 62 <input type="checkbox"/> 63 <input type="checkbox"/> 64 <input type="checkbox"/> 65 <input type="checkbox"/> 66 <input type="checkbox"/> 67 <input type="checkbox"/> 68 <input type="checkbox"/> 69 <input type="checkbox"/> 70 <input type="checkbox"/> 71 <input type="checkbox"/> 72 <input type="checkbox"/> 73 <input type="checkbox"/> 74 <input type="checkbox"/> 75 <input type="checkbox"/> 76 <input type="checkbox"/> 77 <input type="checkbox"/> 78 <input type="checkbox"/> 79 <input type="checkbox"/> 80 <input type="checkbox"/> 81 <input type="checkbox"/> 82 <input type="checkbox"/> 83 <input type="checkbox"/> 84 <input type="checkbox"/> 85 <input type="checkbox"/> 86 <input type="checkbox"/> 87 <input type="checkbox"/> 88 <input type="checkbox"/> 89 <input type="checkbox"/> 90 <input type="checkbox"/> 91 <input type="checkbox"/> 92 <input type="checkbox"/> 93 <input type="checkbox"/> 94 <input type="checkbox"/> 95 <input type="checkbox"/> 96 <input type="checkbox"/> 97 <input type="checkbox"/> 98 <input type="checkbox"/> 99 <input type="checkbox"/> 100 <input type="checkbox"/> 101 <input type="checkbox"/> 102 <input type="checkbox"/> 103 <input type="checkbox"/> 104 <input type="checkbox"/> 105 <input type="checkbox"/> 106 <input type="checkbox"/> 107 <input type="checkbox"/> 108 <input type="checkbox"/> 109 <input type="checkbox"/> 110 <input type="checkbox"/> 111 <input type="checkbox"/> 112 <input type="checkbox"/> 113 <input type="checkbox"/> 114 <input type="checkbox"/> 115 <input type="checkbox"/> 116 <input type="checkbox"/> 117 <input type="checkbox"/> 118 <input type="checkbox"/> 119 <input type="checkbox"/> 120 <input type="checkbox"/> 121 <input type="checkbox"/> 122 <input type="checkbox"/> 123 <input type="checkbox"/> 124 <input type="checkbox"/> 125 <input type="checkbox"/> 126 <input type="checkbox"/> 127 <input type="checkbox"/> 128 <input type="checkbox"/> 129 <input type="checkbox"/> 130 <input type="checkbox"/> 131 <input type="checkbox"/> 132 <input type="checkbox"/> 133 <input type="checkbox"/> 134 <input type="checkbox"/> 135 <input type="checkbox"/> 136 <input type="checkbox"/> 137 <input type="checkbox"/> 138 <input type="checkbox"/> 139 <input type="checkbox"/> 140 <input type="checkbox"/> 141 <input type="checkbox"/> 142 <input type="checkbox"/> 143 <input type="checkbox"/> 144 <input type="checkbox"/> 145 <input type="checkbox"/> 146 <input type="checkbox"/> 147 <input type="checkbox"/> 148 <input type="checkbox"/> 149 <input type="checkbox"/> 150 <input type="checkbox"/> 151 <input type="checkbox"/> 152 <input type="checkbox"/> 153 <input type="checkbox"/> 154 <input type="checkbox"/> 155 <input type="checkbox"/> 156 <input type="checkbox"/> 157 <input type="checkbox"/> 158 <input type="checkbox"/> 159 <input type="checkbox"/> 160 <input type="checkbox"/> 161 <input type="checkbox"/> 162 <input type="checkbox"/> 163 <input type="checkbox"/> 164 <input type="checkbox"/> 165 <input type="checkbox"/> 166 <input type="checkbox"/> 167 <input type="checkbox"/> 168 <input type="checkbox"/> 169 <input type="checkbox"/> 170 <input type="checkbox"/> 171 <input type="checkbox"/> 172 <input type="checkbox"/> 173 <input type="checkbox"/> 174 <input type="checkbox"/> 175 <input type="checkbox"/> 176 <input type="checkbox"/> 177 <input type="checkbox"/> 178 <input type="checkbox"/> 179 <input type="checkbox"/> 180 <input type="checkbox"/> 181 <input type="checkbox"/> 182 <input type="checkbox"/> 183 <input type="checkbox"/> 184 <input type="checkbox"/> 185 <input type="checkbox"/> 186 <input type="checkbox"/> 187 <input type="checkbox"/> 188 <input type="checkbox"/> 189 <input type="checkbox"/> 190 <input type="checkbox"/> 191 <input type="checkbox"/> 192 <input type="checkbox"/> 193 <input type="checkbox"/> 194 <input type="checkbox"/> 195 <input type="checkbox"/> 196 <input type="checkbox"/> 197 <input type="checkbox"/> 198 <input type="checkbox"/> 199 <input type="checkbox"/> 200 <input type="checkbox"/> 201 <input type="checkbox"/> 202 <input type="checkbox"/> 203 <input type="checkbox"/> 204 <input type="checkbox"/> 205 <input type="checkbox"/> 206 <input type="checkbox"/> 207 <input type="checkbox"/> 208 <input type="checkbox"/> 209 <input type="checkbox"/> 210 <input type="checkbox"/> 211 <input type="checkbox"/> 212 <input type="checkbox"/> 213 <input type="checkbox"/> 214 <input type="checkbox"/> 215 <input type="checkbox"/> 216 <input type="checkbox"/> 217 <input type="checkbox"/> 218 <input type="checkbox"/> 219 <input type="checkbox"/> 220 <input type="checkbox"/> 221 <input type="checkbox"/> 222 <input type="checkbox"/> 223 <input type="checkbox"/> 224 <input type="checkbox"/> 225 <input type="checkbox"/> 226 <input type="checkbox"/> 227 <input type="checkbox"/> 228 <input type="checkbox"/> 229 <input type="checkbox"/> 230 <input type="checkbox"/> 231 <input type="checkbox"/> 232 <input type="checkbox"/> 233 <input type="checkbox"/> 234 <input type="checkbox"/> 235 <input type="checkbox"/> 236 <input type="checkbox"/> 237 <input type="checkbox"/> 238 <input type="checkbox"/> 239 <input type="checkbox"/> 240 <input type="checkbox"/> 241 <input type="checkbox"/> 242 <input type="checkbox"/> 243 <input type="checkbox"/> 244 <input type="checkbox"/> 245 <input type="checkbox"/> 246 <input type="checkbox"/> 247 <input type="checkbox"/> 248 <input type="checkbox"/> 249 <input type="checkbox"/> 250 <input type="checkbox"/> 251 <input type="checkbox"/> 252 <input type="checkbox"/> 253 <input type="checkbox"/> 254 <input type="checkbox"/> 255 <input type="checkbox"/> 256 <input type="checkbox"/> 257 <input type="checkbox"/> 258 <input type="checkbox"/> 259 <input type="checkbox"/> 260 <input type="checkbox"/> 261 <input type="checkbox"/> 262 <input type="checkbox"/> 263 <input type="checkbox"/> 264 <input type="checkbox"/> 265 <input type="checkbox"/> 266 <input type="checkbox"/> 267 <input type="checkbox"/> 268 <input type="checkbox"/> 269 <input type="checkbox"/> 270 <input type="checkbox"/> 271 <input type="checkbox"/> 272 <input type="checkbox"/> 273 <input type="checkbox"/> 274 <input type="checkbox"/> 275 <input type="checkbox"/> 276 <input type="checkbox"/> 277 <input type="checkbox"/> 278 <input type="checkbox"/> 279 <input type="checkbox"/> 280 <input type="checkbox"/> 281 <input type="checkbox"/> 282 <input type="checkbox"/> 283 <input type="checkbox"/> 284 <input type="checkbox"/> 285 <input type="checkbox"/> 286 <input type="checkbox"/> 287 <input type="checkbox"/> 288 <input type="checkbox"/> 289 <input type="checkbox"/> 290 <input type="checkbox"/> 291 <input type="checkbox"/> 292 <input type="checkbox"/> 293 <input type="checkbox"/> 294 <input type="checkbox"/> 295 <input type="checkbox"/> 296 <input type="checkbox"/> 297 <input type="checkbox"/> 298 <input type="checkbox"/> 299 <input type="checkbox"/> 300 <input type="checkbox"/> 301 <input type="checkbox"/> 302 <input type="checkbox"/> 303 <input type="checkbox"/> 304 <input type="checkbox"/> 305 <input type="checkbox"/> 306 <input type="checkbox"/> 307 <input type="checkbox"/> 308 <input type="checkbox"/> 309 <input type="checkbox"/> 310 <input type="checkbox"/> 311 <input type="checkbox"/> 312 <input type="checkbox"/> 313 <input type="checkbox"/> 314 <input type="checkbox"/> 315 <input type="checkbox"/> 316 <input type="checkbox"/> 317 <input type="checkbox"/> 318 <input type="checkbox"/> 319 <input type="checkbox"/> 320 <input type="checkbox"/> 321 <input type="checkbox"/> 322 <input type="checkbox"/> 323 <input type="checkbox"/> 324 <input type="checkbox"/> 325 <input type="checkbox"/> 326 <input type="checkbox"/> 327 <input type="checkbox"/> 328 <input type="checkbox"/> 329 <input type="checkbox"/> 330 <input type="checkbox"/> 331 <input type="checkbox"/> 332 <input type="checkbox"/> 333 <input type="checkbox"/> 334 <input type="checkbox"/> 335 <input type="checkbox"/> 336 <input type="checkbox"/> 337 <input type="checkbox"/> 338 <input type="checkbox"/> 339 <input type="checkbox"/> 340 <input type="checkbox"/> 341 <input type="checkbox"/> 342 <input type="checkbox"/> 343 <input type="checkbox"/> 344 <input type="checkbox"/> 345 <input type="checkbox"/> 346 <input type="checkbox"/> 347 <input type="checkbox"/> 348 <input type="checkbox"/> 349 <input type="checkbox"/> 350 <input type="checkbox"/> 351 <input type="checkbox"/> 352 <input type="checkbox"/> 353 <input type="checkbox"/> 354 <input type="checkbox"/> 355 <input type="checkbox"/> 356 <input type="checkbox"/> 357 <input type="checkbox"/> 358 <input type="checkbox"/> 359 <input type="checkbox"/> 360 <input type="checkbox"/> 361 <input type="checkbox"/> 362 <input type="checkbox"/> 363 <input type="checkbox"/> 364 <input type="checkbox"/> 365 <input type="checkbox"/> 366 <input type="checkbox"/> 367 <input type="checkbox"/> 368 <input type="checkbox"/> 369 <input type="checkbox"/> 370 <input type="checkbox"/> 371 <input type="checkbox"/> 372 <input type="checkbox"/> 373 <input type="checkbox"/> 374 <input type="checkbox"/> 375 <input type="checkbox"/> 376 <input type="checkbox"/> 377 <input type="checkbox"/> 378 <input type="checkbox"/> 379 <input type="checkbox"/> 380 <input type="checkbox"/> 381 <input type="checkbox"/> 382 <input type="checkbox"/> 383 <input type="checkbox"/> 384 <input type="checkbox"/> 385 <input type="checkbox"/> 386 <input type="checkbox"/> 387 <input type="checkbox"/> 388 <input type="checkbox"/> 389 <input type="checkbox"/> 390 <input type="checkbox"/> 391 <input type="checkbox"/> 392 <input type="checkbox"/> 393 <input type="checkbox"/> 394 <input type="checkbox"/> 395 <input type="checkbox"/> 396 <input type="checkbox"/> 397 <input type="checkbox"/> 398 <input type="checkbox"/> 399 <input type="checkbox"/> 400 <input type="checkbox"/> 401 <input type="checkbox"/> 402 <input type="checkbox"/> 403 <input type="checkbox"/> 404 <input type="checkbox"/> 405 <input type="checkbox"/> 406 <input type="checkbox"/> 407 <input type="checkbox"/> 408 <input type="checkbox"/> 409 <input type="checkbox"/> 410 <input type="checkbox"/> 411 <input type="checkbox"/> 412 <input type="checkbox"/> 413 <input type="checkbox"/> 414 <input type="checkbox"/> 415 <input type="checkbox"/> 416 <input type="checkbox"/> 417 <input type="checkbox"/> 418 <input type="checkbox"/> 419 <input type="checkbox"/> 420 <input type="checkbox"/> 421 <input type="checkbox"/> 422 <input type="checkbox"/> 423 <input type="checkbox"/> 424 <input type="checkbox"/> 425 <input type="checkbox"/> 426 <input type="checkbox"/> 427 <input type="checkbox"/> 428 <input type="checkbox"/> 429 <input type="checkbox"/> 430 <input type="checkbox"/> 431 <input type="checkbox"/> 432 <input type="checkbox"/> 433 <input type="checkbox"/> 434 <input type="checkbox"/> 435 <input type="checkbox"/> 436 <input type="checkbox"/> 437 <input type="checkbox"/> 438 <input type="checkbox"/> 439 <input type="checkbox"/> 440 <input type="checkbox"/> 441 <input type="checkbox"/> 442 <input type="checkbox"/> 443 <input type="checkbox"/> 444 <input type="checkbox"/> 445 <input type="checkbox"/> 446 <input type="checkbox"/> 447 <input type="checkbox"/> 448 <input type="checkbox"/> 449 <input type="checkbox"/> 450 <input type="checkbox"/> 451 <input type="checkbox"/> 452 <input type="checkbox"/> 453 <input type="checkbox"/> 454 <input type="checkbox"/> 455 <input type="checkbox"/> 456 <input type="checkbox"/> 457 <input type="checkbox"/> 458 <input type="checkbox"/> 459 <input type="checkbox"/> 460 <input type="checkbox"/> 461 <input type="checkbox"/> 462 <input type="checkbox"/> 463 <input type="checkbox"/> 464 <input type="checkbox"/> 465 <input type="checkbox"/> 466 <input type="checkbox"/> 467 <input type="checkbox"/> 468 <input type="checkbox"/> 469 <input type="checkbox"/> 470 <input type="checkbox"/> 471 <input type="checkbox"/> 472 <input type="checkbox"/> 473 <input type="checkbox"/> 474 <input type="checkbox"/> 475 <input type="checkbox"/> 476 <input type="checkbox"/> 477 <input type="checkbox"/> 478 <input type="checkbox"/> 479 <input type="checkbox"/> 480 <input type="checkbox"/> 481 <input type="checkbox"/> 482 <input type="checkbox"/> 483 <input type="checkbox"/> 484 <input type="checkbox"/> 485 <input type="checkbox"/> 486 <input type="checkbox"/> 487 <input type="checkbox"/> 488 <input type="checkbox"/> 489 <input type="checkbox"/> 490 <input type="checkbox"/> 491 <input type="checkbox"/> 492 <input type="checkbox"/> 493 <input type="checkbox"/> 494 <input type="checkbox"/> 495 <input type="checkbox"/> 496 <input type="checkbox"/> 497 <input type="checkbox"/> 498 <input type="checkbox"/> 499 <input type="checkbox"/> 500 <input type="checkbox"/> 501 <input type="checkbox"/> 502 <input type="checkbox"/> 503 <input type="checkbox"/> 504 <input type="checkbox"/> 505 <input type="checkbox"/> 506 <input type="checkbox"/> 507 <input type="checkbox"/> 508 <input type="checkbox"/> 509 <input type="checkbox"/> 510 <input type="checkbox"/> 511 <input type="checkbox"/> 512 <input type="checkbox"/> 513 <input type="checkbox"/> 514 <input type="checkbox"/> 515 <input type="checkbox"/> 516 <input type="checkbox"/> 517 <input type="checkbox"/> 518 <input type="checkbox"/> 519 <input type="checkbox"/> 520 <input type="checkbox"/> 521 <input type="checkbox"/> 522 <input type="checkbox"/> 523 <input type="checkbox"/> 524 <input type="checkbox"/> 525 <input type="checkbox"/> 526 <input type="checkbox"/> 527 <input type="checkbox"/> 528 <input type="checkbox"/> 529 <input type="checkbox"/> 530 <input type="checkbox"/> 531 <input type="checkbox"/> 532 <input type="checkbox"/> 533 <input type="checkbox"/> 534 <input type="checkbox"/> 535 <input type="checkbox"/> 536 <input type="checkbox"/> 537 <input type="checkbox"/> 538 <input type="checkbox"/> 539 <input type="checkbox"/> 540 <input type="checkbox"/> 541 <input type="checkbox"/> 542 <input type="checkbox"/> 543 <input type="checkbox"/> 544 <input type="checkbox"/> 545 <input type="checkbox"/> 546 <input type="checkbox"/> 547 <input type="checkbox"/> 548 <input type="checkbox"/> 549 <input type="checkbox"/> 550 <input type="checkbox"/> 551 <input type="checkbox"/> 552 <input type="checkbox"/> 553 <input type="checkbox"/> 554 <input type="checkbox"/> 555 <input type="checkbox"/> 556 <input type="checkbox"/> 557 <input type="checkbox"/> 558 <input type="checkbox"/> 559 <input type="checkbox"/> 560 <input type="checkbox"/> 561 <input type="checkbox"/> 562 <input type="checkbox"/> 563 <input type="checkbox"/> 564 <input type="checkbox"/> 565 <input type="checkbox"/> 566 <input type="checkbox"/> 567 <input type="checkbox"/> 568 <input type="checkbox"/> 569 <input type="checkbox"/> 570 <input type="checkbox"/> 571 <input type="checkbox"/> 572 <input type="checkbox"/> 573 <input type="checkbox"/> 574 <input type="checkbox"/> 575 <input type="checkbox"/> 576 <input type="checkbox"/> 577 <input type="checkbox"/> 578 <input type="checkbox"/> 579 <input type="checkbox"/> 580 <input type="checkbox"/> 581 <input type="checkbox"/> 582 <input type="checkbox"/> 583 <input type="checkbox"/> 584 <input type="checkbox"/> 585 <input type="checkbox"/> 586 <input type="checkbox"/> 587 <input type="checkbox"/> 588 <input type="checkbox"/> 589 <input type="checkbox"/> 590 <input type="checkbox"/> 591 <input type="checkbox"/> 592 <input type="checkbox"/> 593 <input type="checkbox"/> 594 <input type="checkbox"/> 595 <input type="checkbox"/> 596 <input type="checkbox"/> 597 <input type="checkbox"/> 598 <input type="checkbox"/> 599 <input type="checkbox"/> 600 <input type="checkbox"/> 601 <input type="checkbox"/> 602 <input type="checkbox"/> 603 <input type="checkbox"/> 604 <input type="checkbox"/> 605 <input type="checkbox"/> 606 <input type="checkbox"/> 607 <input type="checkbox"/> 608 <input type="checkbox"/> 609 <input type="checkbox"/> 610 <input type="checkbox"/> 611 <input type="checkbox"/> 612 <input type="checkbox"/> 613 <input type="checkbox"/> 614 <input type="checkbox"/> 615 <input type="checkbox"/> 616 <input type="checkbox"/> 617 <input type="checkbox"/> 618 <input type="checkbox"/> 619 <input type="checkbox"/> 620 <input type="checkbox"/> 621 <input type="checkbox"/> 622 <input type="checkbox"/> 623 <input type="checkbox"/> 624 <input type="checkbox"/> 625 <input type="checkbox"/> 626 <input type="checkbox"/> 627 <input type="checkbox"/> 628 <input type="checkbox"/> 629 <input type="checkbox"/> 630 <input type="checkbox"/> 631 <input type="checkbox"/> 632 <input type="checkbox"/> 633 <input type="checkbox"/> 634 <input type="checkbox"/> 635 <input type="checkbox"/> 636 <input type="checkbox"/> 637 <input type="checkbox"/> 638 <input type="checkbox"/> 639 <input type="checkbox"/> 640 <input type="checkbox"/> 641 <input type="checkbox"/> 642 <input type="checkbox"/> 643 <input type="checkbox"/> 644 <input type="checkbox"/> 645 <input type="checkbox"/> 646 <input type="checkbox"/> 647 <input type="checkbox"/> 648 <input type="checkbox"/> 649 <input type="checkbox"/> 650 <input type="checkbox"/> 651 <input type="checkbox"/> 652 <input type="checkbox"/> 653 <input type="checkbox"/> 654 <input type="checkbox"/> 655 <input type="checkbox"/> 656 <input type="checkbox"/> 657 <input type="checkbox"/> 658 <input type="checkbox"/> 659 <input type="checkbox"/> 660 <input type="checkbox"/> 661 <input type="checkbox"/> 662 <input type="checkbox"/> 663 <input type="checkbox"/> 664 <input type="checkbox"/> 665 <input type="checkbox"/> 666 <input type="checkbox"/> 667 <input type="checkbox"/> 668 <input type="checkbox"/> 669 <input type="checkbox"/> 670 <input type="checkbox"/> 671 <input type="checkbox"/> 672 <input type="checkbox"/> 673 <input type="checkbox"/> 674 <input type="checkbox"/> 675 <input type="checkbox"/> 676 <input type="checkbox"/> 677 <input type="checkbox"/> 678 <input type="checkbox"/> 679 <input type="checkbox"/> 680 <input type="checkbox"/> 681 <input type="checkbox"/> 682 <input type="checkbox"/> 683 <input type="checkbox"/> 684 <input type="checkbox"/> 685 <input type="checkbox"/> 686 <input type="checkbox"/> 687 <input type="checkbox"/> 688 <input type="checkbox"/> 689 <input type="checkbox"/> 690 <input type="checkbox"/> 691 <input type="checkbox"/> 692 <input type="checkbox"/> 693 <input type="checkbox"/> 694 <input type="checkbox"/> 695 <input type="checkbox"/> 696 <input type="checkbox"/> 697 <input type="checkbox"/> 698 <input type="checkbox"/> 699 <input type="checkbox"/> 700 <input type="checkbox"/> 701 <input type="checkbox"/> 702 <input type="checkbox"/> 703 <input type="checkbox"/> 704 <input type="checkbox"/> 705 <input type="checkbox"/> 706 <input type="checkbox"/> 707 <input type="checkbox"/> 708 <input type="checkbox"/> 709 <input type="checkbox"/> 710 <input type="checkbox"/> 711 <input type="checkbox"/> 712 <input type="checkbox"/> 713 <input type="checkbox"/> 714 <input type="checkbox"/> 715 <input type="checkbox"/> 716 <input type="checkbox"/> 717 <input type="checkbox"/> 718 <input type="checkbox"/> 719 <input type="checkbox"/> 720 <input type="checkbox"/> 721 <input type="checkbox"/> 722 <input type="checkbox"/> 723 <input type="checkbox"/> 724 <input type="checkbox"/> 725 <input type="checkbox"/> 726 <input type="checkbox"/> 727 <input type="checkbox"/> 728 <input type="checkbox"/> 729 <input type="checkbox"/> 730 <input type="checkbox"/> 731 <input type="checkbox"/> 732 <input type="checkbox"/> 733 <input type="checkbox"/> 734 <input type="checkbox"/> 735 <input type="checkbox"/> 736 <input type="checkbox"/> 737 <input type="checkbox"/> 738 <input type="checkbox"/> 739 <input type="checkbox"/> 740 <input type="checkbox"/> 741 <input type="checkbox"/> 742 <input type="checkbox"/> 743 <input type="checkbox"/> 744 <input type="checkbox"/> 745 <input type="checkbox"/> 746 <input type="checkbox"/> 747 <input type="checkbox"/> 748 <input type="checkbox"/> 749 <input type="checkbox"/> 750 <input type="checkbox"/> 751 <input type="checkbox"/> 752 <input type="checkbox"/> 753 <input type="checkbox"/> 754 <input type="checkbox"/> 755 <input type="checkbox"/> 756 <input type="checkbox"/> 757 <input type="checkbox"/> 758 <input type="checkbox"/> 759 <input type="checkbox"/> 760 <input type="checkbox"/> 761 <input type="checkbox"/> 762 <input type="checkbox"/> 763 <input type="checkbox"/> 764 <input type="checkbox"/> 765 <input type="checkbox"/> 766 <input type="checkbox"/> 767 <input type="checkbox"/> 768 <input type="checkbox"/> 769 <input type="checkbox"/> 770 <input type="checkbox"/> 771 <input type="checkbox"/> 772 <input type="checkbox"/> 773 <input type="checkbox"/> 774 <input type="checkbox"/> 775 <input type="checkbox"/> 776 <input type="checkbox"/> 777 <input type="checkbox"/> 778 <input type="checkbox"/> 779 <input type="checkbox"/> 780 <input type="checkbox"/> 781 <input type="checkbox"/> 782 <input type="checkbox"/> 783 <input type="checkbox"/> 784 <input type="checkbox"/> 785 <input type="checkbox"/> 786 <input type="checkbox"/> 787 <input type="checkbox"/> 788 <input type="checkbox"/> 789 <input type="checkbox"/> 790 <input type="checkbox"/> 791 <input type="checkbox"/> 792 <input type="checkbox"/> 793 <input type="checkbox"/> 794 <input type="checkbox"/> 795 <input type="checkbox"/> 796 <input type="checkbox"/> 797 <input type="checkbox"/> 798 <input type="checkbox"/> 799 <input type="checkbox"/> 800 <input type="checkbox"/> 801 <input type="checkbox"/> 802 <input type="checkbox"/> 803 <input type="checkbox"/> 804 <input type="checkbox"/> 805 <input type="checkbox"/> 806 <input type="checkbox"/> 807 <input type="checkbox"/> 808 <input type="checkbox"/> 809 <input type="checkbox"/> 810 <input type="checkbox"/> 811 <input type="checkbox"/> 812 <input type="checkbox"/> 813 <input type="checkbox"/> 814 <input type="checkbox"/> 815 <input type="checkbox"/> 816 <input type="checkbox"/> 817 <input type="checkbox"/> 818 <input type="checkbox"/> 819 <input type="checkbox"/> 820 <input type="checkbox"/> 821 <input type="checkbox"/> 822 <input type="checkbox"/> 823 <input type="checkbox"/> 824 <input type="checkbox"/> 825 <input type="checkbox"/> 826 <input type="checkbox"/> 827 <input type="checkbox"/> 828 <input type="checkbox"/> 829 <input type="checkbox"/> 830 <input type="checkbox"/> 831 <input type="checkbox"/> 832 <input type="checkbox"/> 833 <input type="checkbox"/> 834 <input type="checkbox"/> 835 <input type="checkbox"/> 836 <input type="checkbox"/> 837 <input type="checkbox"/> 838 <input type="checkbox"/> 839 <input type="checkbox"/> 840 <input type="checkbox"/> 841 <input type="checkbox"/> 842 <input type="checkbox"/> 843 <input type="checkbox"/> 844 <input type="checkbox"/> 845 <input type="checkbox"/> 846 <input type="checkbox"/> 847 <input type="checkbox"/> 848 <input type="checkbox"/> 849 <input type="checkbox"/> 850 <input type="checkbox"/> 851 <input type="checkbox"/> 852 <input type="checkbox"/> 853 <input type="checkbox"/> 854 <input type="checkbox"/> 855 <input type="checkbox"/> 856 <input type="checkbox"/> 857 <input type="checkbox"/> 858 <input type="checkbox"/> 859 <input type="checkbox"/> 860 <input type="checkbox"/> 861 <input type="checkbox"/> 862 <input type="checkbox"/> 863 <input type="checkbox"/> 864 <input type="checkbox"/> 865 <input type="checkbox"/> 866 <input type="checkbox"/> 867 <input type="checkbox"/> 868 <input type="checkbox"/> 869 <input type="checkbox"/> 870 <input type="checkbox"/> 871 <input type="checkbox"/> 872 <input type="checkbox"/> 873 <input type="checkbox"/> 874 <input type="checkbox"/> 875 <input type="checkbox"/> 876 <input type="checkbox"/> 877 <input type="checkbox"/> 878 <input type="checkbox"/> 879 <input type="checkbox"/> 880 <input type="checkbox"/> 881 <input type="checkbox"/> 882 <input type="checkbox"/> 883 <input type="checkbox"/> 884 <input type="checkbox"/> 885 <input type="checkbox"/> 886 <input type="checkbox"/> 887 <input type="checkbox"/> 888 <input type="checkbox"/> 889 <input type="checkbox"/> 890 <input type="checkbox"/> 891 <input type="checkbox"/> 892 <input type="checkbox"/> 893 <input type="checkbox"/> 894 <input type="checkbox"/> 895 <input type="checkbox"/> 896 <input type="checkbox"/> 897 <input type="checkbox"/> 898 <input type="checkbox"/> 899 <input type="checkbox"/> 900 <input type="checkbox"/> 901 <input type="checkbox"/> 902 <input type="checkbox"/> 903 <input type="checkbox"/> 904 <input type="checkbox"/> 905 <input type="checkbox"/> 906 <input type="checkbox"/> 907 <input type="checkbox"/> 908 <input type="checkbox"/> 909 <input type="checkbox"/> 910 <input type="checkbox"/> 911 <input type="checkbox"/> 912 <input type="checkbox"/> 913 <input type="checkbox"/> 914 <input type="checkbox"/> 915 <input type="checkbox"/> 916 <input type="checkbox"/> 917 <input type="checkbox"/> 918 <input type="checkbox"/> 919 <input type="checkbox"/> 920 <input type="checkbox"/> 921 <input type="checkbox"/> 922 <input type="checkbox"/> 923 <input type="checkbox"/> 924 <input type="checkbox"/> 925 <input type="checkbox"/> 926 <input type="checkbox"/> 927 <input type="checkbox"/> 928 <input type="checkbox"/> 929 <input type="checkbox"/> 930 <input type="checkbox"/> 931 <input type="checkbox"/> 932 <input type="checkbox"/> 933 <input type="checkbox"/> 934 <input type="checkbox"/> 935 <input type="checkbox"/> 936 <input type="checkbox"/> 937 <input type="checkbox"/> 938 <input type="checkbox"/> 939 <input type="checkbox"/> 940 <input type="checkbox"/> 941 <input type="checkbox"/> 942 <input type="checkbox"/> 943 <input type="checkbox"/> 944 <input type="checkbox"/> 945 <input type="checkbox"/> 946 <input type="checkbox"/> 947 <input type="checkbox"/> 948 <input type="checkbox"/> 949 <input type="checkbox"/> 950 <input type="checkbox"/> 951 <input type="checkbox"/> 952 <input type="checkbox"/> 953 <input type="checkbox"/> 954 <input type="checkbox"/> 955 <input type="checkbox"/> 956 <input type="checkbox"/> 957 <input type="checkbox"/> 958 <input type="checkbox"/> 959 <input type="checkbox"/> 960 <input type="checkbox"/> 961 <input type="checkbox"/> 962 <input type="checkbox"/> 963 <input type="checkbox"/> 964 <input type="checkbox"/> 965 <input type="checkbox"/> 966 <input type="checkbox"/> 967 <input type="checkbox"/> 968 <input type="checkbox"/>							



3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05659

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05664

1. DECEASED NAME (Type or print)				First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR Year
<i>Cecelia McKeown Leighton</i>						4 4 69	9:00 AM	
3. SEX		4 RACE	5 DATE OF BIRTH			6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White	17 Sept 1887			81 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED			9. COUNTY OF DEATH		
Penn		U.S.	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring, Md.		10045 Mansion St.			Housewife		own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMIT?	13e. STREET AND NUMBER			
Md.		Montgomery	Silver Spring	X	10045 Mansion St.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			
		Andrew		Brown	First		Middle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		none		McLaughlin Funeral Home Wilkes Barre, Penn				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <i>cerebral vascular accident, thrombosis</i> cerebral 8 days								
405.7 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) (b) <i>cerebral arteris sclerosis</i> 5 yrs								
stating the underlying cause (c) <i>generalized arteriosclerosis</i> 15 yrs								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						<input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTR BUT NO <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 1968</i> , to <i>Sept 1969</i> that (I) (we) last saw the deceased alive on <i>3 April 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE			ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED	
<i>Merton J. White</i>							<i>Sept 1969</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Merton J. White		<i>9911 George St. Silver Spring MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (CITY or TOWN) (Country) (State)		
		<i>4/8/69</i>	<i>St. Mary's Cemetery</i>			<i>Hanover Township, Penn</i>		
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR	25b. REC'D STAR'S SIGNATURE		
<i>Warner C. Purphrey Inc.</i>		<i>8434 Georgia Ave. Silver Spring, Md.</i>			<i>APR 11 1969</i>	<i>V. L. Gandy</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05665

05660

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First AGNES	Middle V	Last LEON	2a. DATE OF DEATH Month APRIL	Day 6	Year 1969	2b. HOUR 6:10 P.M.	
3. SEX FEMALE		4. RACE WHITE		S. DATE OF BIRTH 1/13/191	6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 78	IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH SILVER SPRING MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRFIELD Nursing		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE M.D.		13c. CITY OR TOWN MONTGOMERY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6014 ONONDAGA RD.				
14. FATHER'S NAME First ALEX		Middle —	Last ST. JOHN	15. MOTHER'S MAIDEN NAME First MARY		Middle —	Last CAULFIELD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 577-68-687		17. INFORMANT DR. HERBERT LEON, SAME AS # 13		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 <i>decrepitile shock</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause hypertension 244.									
DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarct 267 DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pyelonephritis - Hypertension - Arthritis									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med-coll examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 4/15/69 , to 4/16/69 , that (I) (we) lost saw the deceased alive on 4/15/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE RICHARD O' DELANEY		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/6/69					
22d. PHYSICIAN'S NAME (Type) RICHARD O' DELANEY		22e. ADDRESS 4323 HARVARD, SILVER SPRING, MD.							
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) BURIAL		23b. DATE 4/9/69		23c. NAME OF CEMETERY OR CREMATORIUM HOLY ROAD CEM.		23d. LOCATION (City or Town) WASHINGTON, D.C.		(County) (State)	
24. FUNERAL DIRECTOR JOS. GAWLER'S SON, 5130 LUIS AVE. N.W. WASHINGTON, D.C.		ADDRESS		25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE Charles J. ...			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05666

05661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If you have any questions, call the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH	2b. HOUR
(Baby Girl) LEPIANE				4 Month 21 Day 69 Year	1:30 PM
3. SEX FEMALE	4 RACE WHITE	S. DATE OF BIRTH 4/20/69	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13b. COUNTY Pr. Geo's Grnblt	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9168 Springhill Lane	
14. FATHER'S NAME DONALD CARL LEPIANE	15. MOTHER'S MAIDEN NAME GLORIA L.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT Donald Carl Lepiane - father same #13	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) IMMATURITY 71.9.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b) PREMATURE RUPTURE OF MEMBRANES AT 4 MONTHS DUE TO, OR AS A CONSEQUENCE OF (c) INCOMPETENT CERVICAL OS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this-hospital) attended the deceased from 4/20/69, 1969, to 4/21, 1969, that (I) (we) last saw the deceased alive on 4/21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Herbert J Friedel, M.D.		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 4/23/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 11014 New Hampshire, St. Spr., Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/69	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) Silver Spring, Md.	(County) (State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rock Pike Rockville, Md.	25a. REC'D BY REGISTRAR APR 28 1969	25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 30M REV. 10/64					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05667

05662

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Mary	Middle C.	Last Lewis	2a. DATE OF DEATH Month April	Day 17	Year 1969	2b. HOUR 3²⁸ M	
3. SEX Female		4 RACE white	5. DATE OF BIRTH 12/23/82		6. AGE (in years last birthday) 88 yrs.		26. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) TEXAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Grosvenor Lane Nursing Home		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Town Home			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. CITY OR TOWN Montgomery Silver Spring	13c. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 10915 OAKwood St.				
14. FATHER'S NAME First Henry		Middle Cumpston	15. MOTHER'S MAIDEN NAME First Mary		Middle Cumpston	Address Charles F. Lewis (son) Same as # 13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 220 54 2387		17. INFORMANT Charles F. Lewis (son) Same as # 13		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic H. disease		DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis		DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med col examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1969 , to 4/17, 1969 , that (I) (we) last saw the deceased alive on 4/16/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lorraine W. Barr, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Apr 21 1969		
22d. PHYSICIAN'S NAME (Type) Ronald W. Barr, M.D.		22e. ADDRESS 10401 Old Georgetown Rd Bethesda							
23a. BURIAL CREMATION REMOVED Buried		23b. DATE 4/20/69	23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City or Town) Blooming Grove		(County) Navarro	(State)	
24. FUNERAL DIRECTOR Francis Hasch's Sons Funeral Home, Md.		ADDRESS 4739 Baltimore Ave., Hyattsville		REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE James J. Hayes			

soft, white
soy
water of P
clothes
will not eat spider

FOR STATE
HEALTH DEPT.

DEPARTMENT OF
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

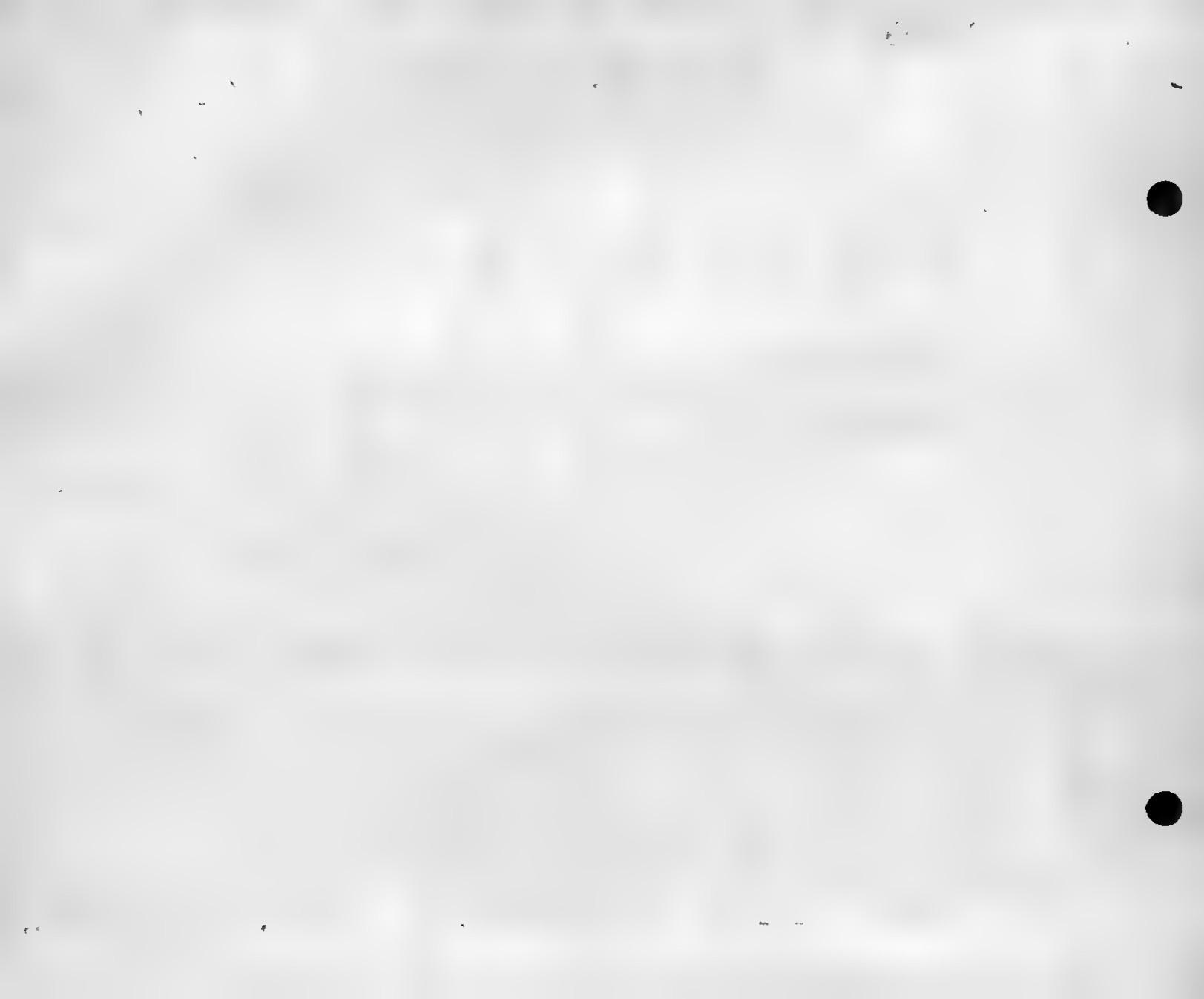
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Dept. prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05663

1 DECEASED NAME (Type or Print)	First Margaret		Middle H.	2 Lost Line	2a DATE KNOWN OF ESTI- DEATH MATED	Month 4	Day 24	Year 69	2b HOUR 11 AM
3 SEX	4 PLACE	5 DATE OF BIRTH	6 AGE (in years at time of death) 65 yrs	7 UNDER 1 YEAR	8 IF UNDER 24 HRS				
7b BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	2c DATE PRONOUNCED DEAD Month 4 Year 69	2d HOUR 12 PM			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring	1311 Holoridoe Rd.								
13a USUAL RESIDENCE (Where deceased died, if institution. Residence before admission) STATE Md.	13b COUNTY Montgomery	13c CITY OR TOWN Chevy Chase	13d INSIDE CITY, J.M.T.S?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	2945 Terrace Drive			
14 FATHER'S NAME	First RUDOLPH	Middle	Last LUEDECKE	15 MOTHER'S MAIDEN NAME	First ANNA	Middle RICHTER	Last Ludecke		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS						
	141-01-3770	ERIC RAYMOND HAARS, SON, SAME AS #73							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Gunshot wound, left									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Chest, apparently self-inflicted									
DUE TO, OR AS A CONSEQUENCE OF (c) Acute depression									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4-24 1969		21c HOW INJURY OCCURRED (For nature of injury see Part 1 or Part 2 Item 18.) Received self with a cal. pistol shot					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No. City or Town 13213 Holdridge Rd., S.S. Montg. Md.		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> on my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) BELDEN R. REAP M.D. (Signature)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED APRIL 24, 1969	
23a BURIAL CREMATION, REMOVAL (Specify) Cremation		23b DATE 4-28-1969		23c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill Crematory		23d LOCATION (City or Town) Suitland, Prince Georges Co., Md.		(County) (State)	
24 FUNERAL DIRECTOR		JOSEPH GAWLER'S SON, INC. 1730 MUSC. AVE., N. W. WASH., D. C. 20016		25a. REC'D BY REGISTRAR D. MAY 2 1969		25b. REGISTRAR'S SIGNATURE <i>Charles George</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1

05669

05664

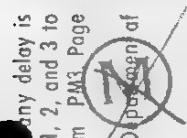
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First May	Middle B	Last Linthicum	2a. DATE OF DEATH Month Apr.	Day 15 '69	Year 8 PM	2b. HOUR 8 15 PM
3. SEX Female	4. RACE W	5. DATE OF BIRTH 5-5-85	6. AGE (In years last birthday) 83	7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery Co
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12325 New Hampshire, S.S.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. before admission) STATE Maryland	13b. CITY OR TOWN Montgomery	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 12604 Pendenville Rd. S.S.				
14. FATHER'S NAME Barribus	First William	Middle Baker	Last James	15. MOTHER'S MAIDEN NAME Ida	Address Mrs. Ida J. Gregg, 12604 Pendenville Rd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO	17. INFORMANT Coronary Ace. -	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) Gun Cr. / coronary heart attack today			
				(c) Gun Cr. / coronary heart attack 2 yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 4181	City or Town 1069	County 4157	State	
22o. I certify that (I) (this hospital) attended the deceased from 4/18/69 to 4/15/69, that (I) (we) last saw the deceased alive on 4/15/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howard Morse, M.D.		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS	<input type="checkbox"/>	22c. DATE SIGNED 4/15/69	
22d. PHYSICIAN'S NAME (Type) Howard T. Morse, M.D.		22e. ADDRESS 7030 Carrollton Tahoma Park Md					
23a. BURIAL/CREMATION, REMOVAL (Society) Burial		23b. DATE April 18, 1969	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor	(County)	(State) Md.	
24. FUNERAL DIRECTOR Howard T. Morse		ADDRESS 254 Carroll St NW	REC'D. BY REGISTRAR APR 18 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 45M - 1 199							



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item# FilmG411
4/22/69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05670

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05665

1 DECEASED-NAME (Type or Print)	First PHILIP	Middle (MM)	Last LIPSCHUTZ	2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/>	Month Day Year April 14 1969	2b HOUR 2:00	
3 SEX Male	4. RACE White	S. DATE OF BIRTH Dec. 7, 1890	6. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0
7a BIRTHPLACE (State or foreign country) Russia	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery	2c. DATE PRONOUNCED DEAD Month Day Year April 14 1969	2d. HOUR 3:00	pin	
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hospt.			12a. USUA. OCCUPATION (Kind of work done during most of work day if not even if retired) Retired Laundry Supplier	12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived at institution Residene before admission) STATE NY	13b. COUNTY	13c. CITY OR TOWN Brooklyn	13d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 2026 Ocean Ave.			
14. FATHER'S NAME First SHLOMO	Middle LIPSCHUTZ	Last LEAH	15 MOTHER'S MAIDEN NAME First LEAH	Middle -	Last -		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16b SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Helen Price 6008 10th Place Chillum Md.	ADDRESS ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute			DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency Acute				
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last:			(b) Cardio-Vascular Disease.			Years Years	
			(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John S. Ball</i>	M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>John S. Ball M.D.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) Address							
23a. FUNERAL CREMATION, REMOVAL. (Specify)	23b. DATE 4/16/69	23c. NAME OF CEMETERY OR CREMATORIAL Dixie Cemetery	23d. LOCATION (City or Town) Alexander	(County) M.D.	(State) N.J.		
24. FUNERAL DIRECTOR Gerald Danganiy & Sons	ADDRESS 350 W. 47th St. N.Y.C.	25a. REC'D. BY REGISTRAR DATE APR 17 1969	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05666

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 05671		2a. DATE OF DEATH Month 4 Day 7 Year 69						2b. HOUR 30 PM	
1. DECEASED NAME (Type or print)	First Joseph	Middle EDGAR	Last Litchfield	5. DATE OF BIRTH 10-17-84		6. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
3. SEX Male	4 RACE White	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md			
7a. BIRTHPLACE (State or foreign country) Maryland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Building Inspector		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Laurel, Md	13b. COUNTY Howard	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 950 Nichols Drive					
14. FATHER'S NAME First Joseph	Middle -	Last Litchfield	15. MOTHER'S MAIDEN NAME First Elizabeth	Middle Brown	Last Litchfield				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT Medical Records	Wash. Address San. & Hosp. Carroll Ave. Takoma PK, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162. i Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours				
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					Brain metastases				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Tumor head of pancreas (scav ox) : ASHD; BPH					Bronchogenic carcinoma L1 Monroe months				
19a. MEDICAL CERTIFICATION DATE OF OPERATION 3/25/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 3/23, 1969, to 4/7, 1969, that (I) (we) last saw the deceased alive on 4/7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Blanche Cruse		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 4/7/69			
22d. PHYSICIAN'S NAME (Type) Danedean Funeral Home, Laurel, Md		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-10-69	23c. NAME OF CEMETERY OR CREMATORIAL Troy Hill Cemetery	23d. LOCATION (City or Town) Laurel Md		(County)		(State)		
24. FUNERAL DIRECTOR Danedean Funeral Home, Laurel, Md	ADDRESS		25a. REC'D. BY REGISTRAR APR 14 1969	25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05672

CERTIFICATE OF DEATH

05667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Fannie	Middle Elizabeth	Last Loun	2a. DATE OF DEATH Month April	Day 17	Year 1969	2b. HOUR P 5:55	
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 9, 1911		6. AGE (In years last birthday) 58	IF UNDER 1 YEAR MONTHS 0	DAYS 0	IF UNDER 24 HRS. HOURS 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Monrovia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD # 1				
14. FATHER'S NAME First Albert	Middle W.	Last Crum	15. MOTHER'S MAIDEN NAME First Evie	Middle May	Last Burke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Records	Address Montgomery General Hospital, Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Failure 7532 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus DUE TO, OR AS A CONSEQUENCE OF (c) Congenital Partial tracheal obstruction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Insufficiency								
19a. DATE OF OPERATION 4/12/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Reoperated Duodenal Ulcer	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.O. No.	City or Town	County	State		
22a. I certify that (I) (This hospital) attended the deceased from 4/11/69 , to 4/17/69 that (I) (we) last saw the deceased alive on 4/17/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Arthur F. Woodward		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 4/18/69			
22d. PHYSICIAN'S NAME (Type) Arthur F. Woodward, M.D.		22e. ADDRESS 115 N. Van Buren St., Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/20/69	23c. NAME OF CEMETERY OR CREMATORIAL Providence Meth.	23d. LOCATION (City or Town) Kempton, Md.	(County)	(State)			
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	ADDRESS	25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles George				
		DATE APR 22 1969						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												05668	
1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED			Month	Day	Year	2b. HOUR	
<i>Emra</i>					<i>Lynn</i>	<input checked="" type="checkbox"/>			4	4	69	7:20 P.M.	
3. SEX	4. RACE	DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR	
Female	White	Dec. 8, 1876	92 YRS.	MONTHS	DAYS	<input checked="" type="checkbox"/>			4	4	69	7:20 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Lima, Peru		USA				Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDSTRY				
Takoma Park			8519-Garland Avenue			Housewife			Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER				
Maryland			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8519 Garland Avenue				
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost		
Heinrich					Hildebrand	Barbara					Platzer		
16a. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			Yes			1311 Pinecrest James Lynn (son)			Robert Silver Spring, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <i>Arteriosclerotic Heart Disease</i> (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Belden R. Reap</i>			EXAMINER'S NAME (Type) <i>Belden R. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS: <i>515 S. Spg. Rd.</i> county: <i>Los Angeles, California</i>			22b. DATE SIGNED <i>APRIL 5, 1969</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burner</i>			23b. DATE <i>Apr. 8, 1969</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Inglewood Park Cemetery</i>			23d. LOCATION (City or Town) <i>Los Angeles, California</i> (Co. or City) (State)				
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>			ADDRESS: <i>515 S. Spg. Rd.</i>			25a. REC'D BY REGISTRAR <i>APR 11 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
Warner E. Lumpkin, Inc 8434 Ga. Avenue													



05674

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Information taken from birth cert CERTIFICATE OF DEATH

05669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in every case within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Odetta</i>	Middle <i>RICKI</i>	Last <i>BURKHILL</i>	May	2d. DATE OF DEATH Month <i>APRIL</i>	Doy <i>1969</i>	2b. HOUR <i>4:50</i>
3. SEX <i>Female</i>	4 RACE <i>white</i>	5. DATE OF BIRTH <i>April 1, 1969</i>		6. AGE (In years last birthday) <i>---</i>	IF UNDER 1 YEAR MONTHS <i>10</i>	IF UNDER 24 HRS. DAYS <i>15</i>	IF UNDER 24 HRS. HOURS <i>15</i>
7c. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>---</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATI <i>Md.</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Wheaton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>10902 Backwill Dr.</i>			
14. FATHER'S NAME First <i>No info</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Louise</i>	Middle <i></i>	Last <i>MAY</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i>	16b. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>mother</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Immaturity (Premature)</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATE ON DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Donald J. Straus, MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/1/69</i>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>4301 Aspen Hill Rd. Rockville, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/3/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) <i>Silver Spring, Md.</i>	(County) <i>Montgomery</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>		ADDRESS <i>Rock. Pike</i>	25a. REC'D BY REGISTRAR DATE <i>APR 7 1969</i>		25b. REC'D BY JUDGE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

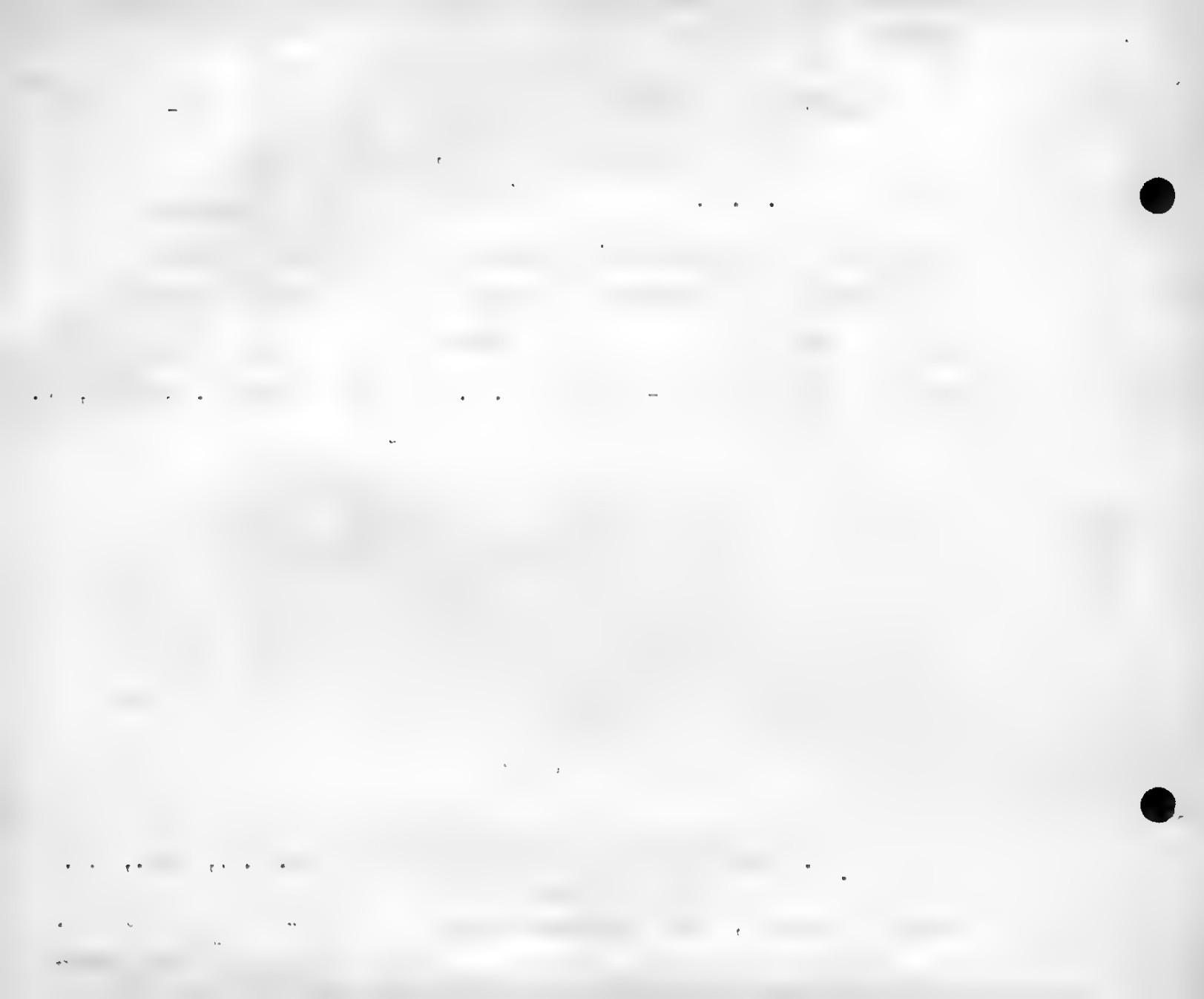
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05675

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05670

1. DECEASED NAME (Type or print)		First	Middle	Lost	2d. DATE OF DEATH	Month	Day	Year		
NATHAN		NORMAN	MAYER		4 - 3 - 1969	3 A				
3. SEX	4. RACE	S. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Caucasian	Jan 5, 1893		76	YRS.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Wheaton		Randolph Hills Nursing Home		Retired - Attorney		Law				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
Maryland		Montgomery		Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6809 Tilden Lane				
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
		unknown			unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		SON		Address		
Yes, WW I		579-14-5307A		J. E. Mayer		6809 Tilden La. Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive heart failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
492 X Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary heart disease						1 week 5 yrs.		
		DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 10/10, 1966, to 4/3, 1969, that (I) (we) last saw the deceased alive on 4/2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>S. W. Nealon Jr.</i>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 4/3/69.				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		915 19th St. N.W., Wash., D.C.						
S. W. Nealon										
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE April 7, 1969	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National		23d. LOCATION (City or Town) Arlington		(County) Arlington		(State) Va.	
24. FUNERAL DIRECTOR		JOSEPH GAWLER'S SON, INC. ADDRESS 6730 WISCONSIN AVE., N. W. WASH., D. C. 20016		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
						DATE APR 7 1969				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

4-1
05676

0567i

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	20. DATE OF DEATH Month	4 - Day	Year	2b. HOUR 6:07 P.M.		
SUE ALICE McNULTY						Month	4 - 15 - 69	Year			
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH 11-29-93			6. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MN			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital g ve street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Md.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. CITY OR TOWN MONT.		13c. INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5015 BATTERY LANE					
14. FATHER'S NAME First Charles A. Collins			15. MOTHER'S Maiden Name First Sarah C. Unglesbee								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO Unknown			17. INFORMANT Husband Same as address Item 13. R. Adm. Richard R. McNulty					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Rupture of the cerebral aneurysm									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) Hypertension						10+ yrs		
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(d)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 1968 to April 15, 1969 , that (I) (we) last saw the deceased alive on 4-15-69 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Fleet Luckett		22c. DEGREE ATTENDING PHYS			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			DATE SIGNED 4-16-69			
22d. PHYSICIAN'S NAME (Type) W. FLEET LUCKETT		22e. ADDRESS 5000 Reno Road, N. W. Washington, D. C.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-18-69		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl Cem.			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.		ADDRESS			25a. REC'D BY REGISTRAR APR 21 1969			25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

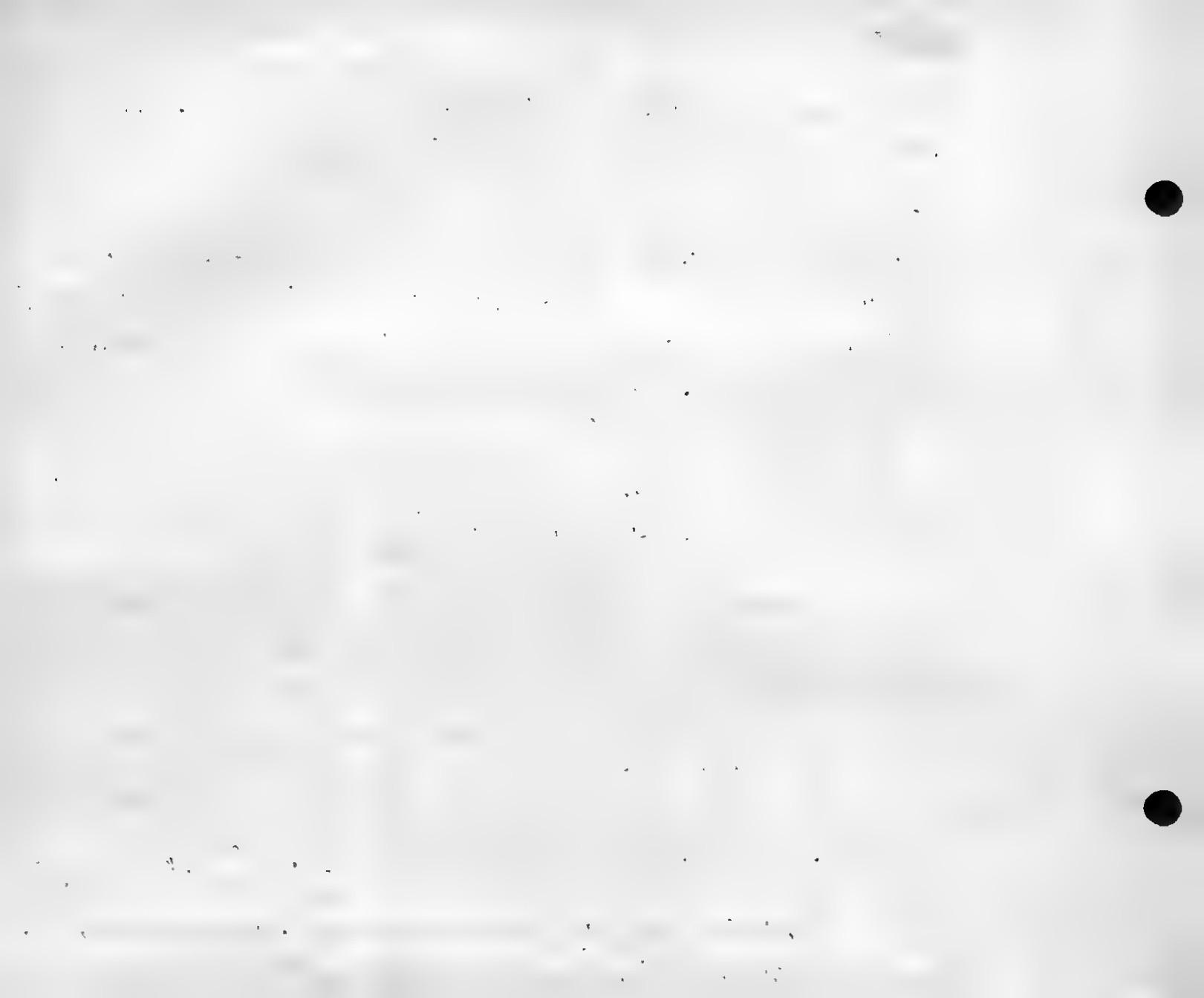
44
05677

05672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Yahya</i>	Middle <i>(None)</i>	Last <i>Melekoglu</i>	2a. DATE OF DEATH Month <i>APRIL</i>	Day <i>30</i>	Year <i>1969</i>	2b HOUR <i>11:25 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>January 1, 1901</i>	6. AGE (In years last birthday) <i>68 yrs</i>		IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Europe - Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>America</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Pan + Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Painter - U.S. Government</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		13e. STREET AND NUMBER <i>2731 FORT BAKER DRIVE, SE</i>					
14. FATHER'S NAME First <i>Ismail</i>		Middle <i>Milicemanovic</i>	Last <i>Fatima</i>	15. MOTHER'S MAIDEN NAME First <i>Redlinska</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>357-95-2359</i>		17. INFORMANT <i>Pt's. Chart</i>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Gastrointestinal hemorrhage</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs - 1 week.</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gastric ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Stomach</i>								6 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
19a. DATE OF OPERATION <i>March 29, 69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Stomach</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>April 16, 1969</i> , to <i>April 30, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 30, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Byse Williams M.D.</i>		ATTENDING DOCTOR PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <i>May 6, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>Byse Williams M.D.</i>		22e. ADDRESS <i>831 University Blvd., Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>5/2/69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>National Memorial Park Cem.</i>		23d. LOCATION (City or Town) <i>Falls Church, Va.</i>		(County)	(State)		
24. FUNERAL DIRECTOR <i>The S.H. Hines Co.</i>		ADDRESS <i>1901-1947th St. N.W. Washington, D.C.</i>		25a. REC'D. BY REGISTRAR DA <i>MAY 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05675

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05678		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						05675	
1. DECEASED-NAME (Type or print) <i>Mella</i>		First ALICE	Middle A.	Last MELIA	2d. DATE OF DEATH Month 4 Day 17 Year 69		2b. HOUR 11 45 M		
3. SEX F		4. RACE W		5. DATE OF BIRTH 10/12/89		6. AGE (in years last birthday) 79 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7d. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Prince George		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 510 Meagan Road			
14. FATHER'S NAME First Unknown		Middle	Last	15. MOTHER'S MAIDEN NAME First Alice		Middle Ann	Last Limerick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address Curtis James Hicks 2716 Kirkwood Pl Hyatt			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>093.9</i> (b) <i>Rheumatic Aortitis and C.N.S. Lues</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>3/30</i> , 19 <i>69</i> , to <i>4/17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/17</i> , 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. A. Ostrow MD</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input checked="" type="checkbox"/>	22c. DATE SIGNED <i>4/18/69</i>
22d. PHYSICIAN'S NAME (Type) DR. BERNARD OSTROW		22e. ADDRESS 8107 Eastern Ave. S.S., Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-21-1969		23c. NAME OF CEMETERY OR CREMATORIAL Home Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland		(County) Maryland (State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland						25a. RECEIVED BY REGISTRAR APR 24 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1
05679

05674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR Year		
HESTER NOREINE MERSEGAU					4 23 69	8 45 M		
3. SEX	F	4. RACE	N	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
				Oct. 14, 1919	49 YRS.			
7a. BIRTHPLACE (State or foreign country)	Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH	Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	2650 Norbeck Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	N.Y.	13c. CITY OR TOWN	N.Y.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
13b. COUNTY	BRONX				1795 Clinton Ave.			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
	WALTER	Awkard		ALICE	Snowden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO	112-26-7758	17. INFORMANT	Robt. MR. MERSEGAU	Address		
						1795 Clinton Ave. N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 1820 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) Metastatic Hepatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma body uterus								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Renal Metastatic Carcinoma, rt.								
19c. MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 3-28, 1969 , to 4-23, 1969 , that (I) (we) last saw the deceased alive on 4-21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE	Oliver J. Jackson, MD				DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS	202 Martin L., Rockville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City or Town) (County) (State)					
BURIAL	4/27/69	Sharp Street Cemetery Sandy Spring Montg. Md.						
24. FUNERAL DIRECTOR					25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
						Charles Judge		
					DATE	APR 28 1969		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05680

05675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please retain page 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

1. DECEASED NAME (Type or print)		First Emile	Middle F.	Last Meyer, Sr.	2a. DATE OF DEATH Month Year April 10 1969 AM	2b. HOUR 10 AM
3. SEX Male		4. RACE White	S. DATE OF BIRTH 1-3-1885	6. AGE (In years last birthday) 87 yrs.	F. UNDER 1 YEAR MONTHS 0	I.F. OVER 24 HRS. DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) La.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) Retired-Southern Pacific Railroad	12b. KIND OF BUSINESS OR INDUSTRY 6408 Earlham Drive	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INS. OR CITY LIM. IS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6408 Earlham Drive	
14. FATHER'S NAME First unknown		Middle Lst	15. MOTHER'S MAIDEN NAME First Middle Last unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No		16b. SOCIAL SECURITY NO.	17. INFORMANT Patricia Meyer, 6408 Earlham Dr., Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		Cerebrovascular accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) Coronary arteriosclerosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 1966, to 4-10, 1967, that (I) (we) last saw the deceased alive on 4-9-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.						
22b. SIGNATURE Jay Shapiro		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/10/1969	
22d. PHYSICIAN'S NAME (Type) Jay R. Shapiro		22e. ADDRESS 8218 Wisc. Ave., Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/12/1969	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	23d. LOCATION (City or Town) Silver Spring,	(County) Md.	(State)
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		1331 Rockville Pike Rockville, Md.	25a. REC'D BY REGISTRAR APR 14 1969	25b. REGISTRAR'S SIGNATURE Charles J. Jones		



FOR STATE
HEALTH DEPT.Items 18&22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-14-69 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05676

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a funeral-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

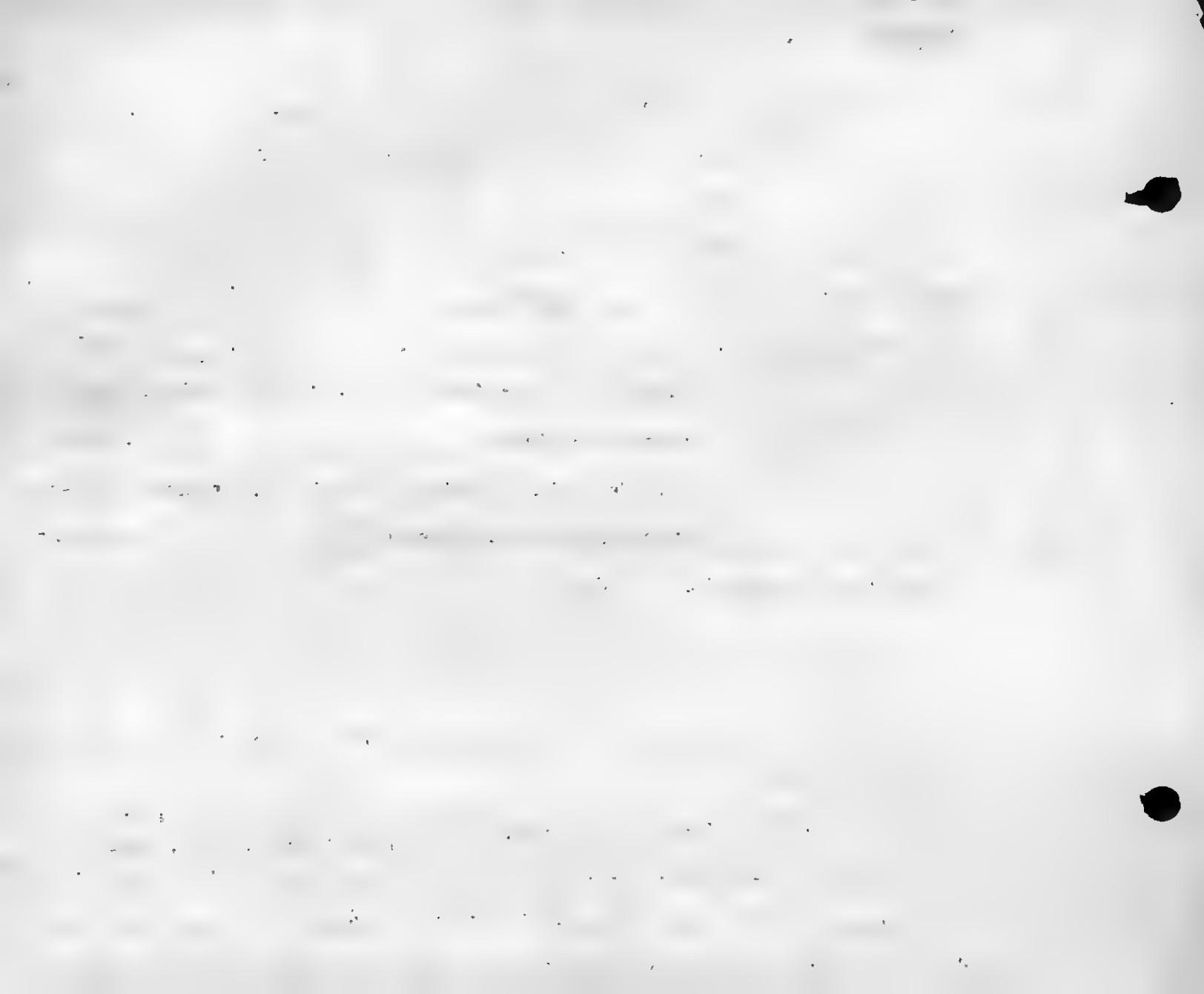
1 DECEASED NAME (Type or Print)	First Eleanor	Middle R	Last Miles	2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month 4 <input type="checkbox"/> Year 13	Day 13 Year 69	2b. HOUR 3:30 AM	
3 SEX Female	4 RACE White	5. DATE OF BIRTH 1-24-15	6 AGE (In years at birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9 COUNTY OF DEATH Montgomery	2c. DATE PRONONCED DEAD Month 4 Year 69			
10. CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased I vied, if institution Residence before admission) STATE Md.	13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER Route #3			
14 FATHER'S NAME Herbert	First L.	Middle Diamond	Last	15 MOTHER'S MAIDEN NAME Mary	Middle	Last Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 577-01-0879	17. INFORMANT Howard Miles, Gaithersburg, Md.	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia; severe DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Peap</i> M.D.							
EXAMINER'S NAME (Type) <i>BELDEN R. PEAP M.D.</i>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, County) <i>Montgomery</i>							
22b. DATE SIGNED <i>4/13/1969</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4-16-69	23c NAME OF CEMETERY OR CREMATORIAL St Rose	23d LOCATION (City or Town) Gaithersburg	(County) Montgomery	(State) Md.		
24 FUNERAL DIRECTOR <i>Ernest C. Gartner.</i>	ADDRESS <i>1101 1/2 E. 6th Street, Gaithersburg, Md.</i>	25a. REC'D BY REGISTRAR APR 16 1969	25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>				



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**
CERTIFICATE OF DEATH

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18 Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items?&8 Film C.71 MARYLAND STATE DEPARTMENT OF HEALTH
4/24/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05678

1. DECEASED-NAME (Type or Print)		First RICHARD		Middle	LOST	2a. DATE KNOWN OF DEATH MATED	Month Day Year	2b HOUR
3 SEX Male	4. RACE Negro	S DATE OF BIRTH	6 AGE (In years and birthday) 81	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d HOUR	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rear of 906 N. Stonestreet Ave.		12a. JSUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res dence before admission) STATE Maryland		13c CITY OR TOWN Montgomery	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER 906 N. Stonestreet Avenue				
14. FATHER'S NAME First		Middle	Last	15. MOTHER'S MAIDEN NAME First		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carbon monoxide intoxication</u></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____</p>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITON FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR MIN. 8:10 PM 4-9-69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Conflagration</u>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No 906 N. Stonestreet Ave.		City or Town Rockville	County Montgomery	State Md.
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>Edward F. Wilson, M.D.</u></p> <p>EXAMINER'S NAME (Type)</p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.</p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.</p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M.D.</p> <p>ADDRESS (Street, city, town, or county) Edward F. Wilson, M.D.</p>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-12-69		23c. NAME OF CEMETERY OR CREMATORIUM Lincoln Park		23d. LOCATION (City or Town) Rockville County, MD		
24. FUNERAL DIRECTOR R.L. Snowden Rockville, Md.		ADDRESS		25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Hodge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05679

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JAMES	Middle FRANKLIN	Last MINTON	2a. DATE OF DEATH APRIL 30 1969	2b. HOUR 11:30 P.M.
3. SEX MALE	4. RACE CAU	5. DATE OF BIRTH 18MAR23		6. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) TENN	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 32 NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) VA. BEACH		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VA.	13b. COUNTY	13c. CITY OR TOWN VA. BEACH	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 464 LYNN SHORES DRIVE	
14. FATHER'S NAME AUBURN	First CLAUDE	Middle MINTON	15. MOTHER'S MAIDEN NAME First MAUDE	Middle NMN	Last McDOWELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>Yes</u>	16b. SOCIAL SECURITY NO. <u>266-22-6774</u>	17. INFORMANT MRS. VIVIAN MINTON	Address VA. BEACH VA.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with widespread metastases</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<u>1517</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (1) (this hospital) attended the deceased from Mar. 12, 1969, to Apr. 30, 1969, that (2) (we) last saw the deceased alive on Apr. 30, 1969, and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Donald K. Roeder</i>		22c. DATE SIGNED <i>1 May 69</i>	DEGREE ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.
22d. PHYSICIAN'S NAME (Type) Donald K. ROEDER, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <i>5-5-69</i>	23c. NAME OF CEMETERY OR CREMATORIAL —		23d. LOCATION (City or Town) VIRGINIA BEACH, VA (County) (State)
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin St., N.W. Washington, D.C.			25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 1-8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

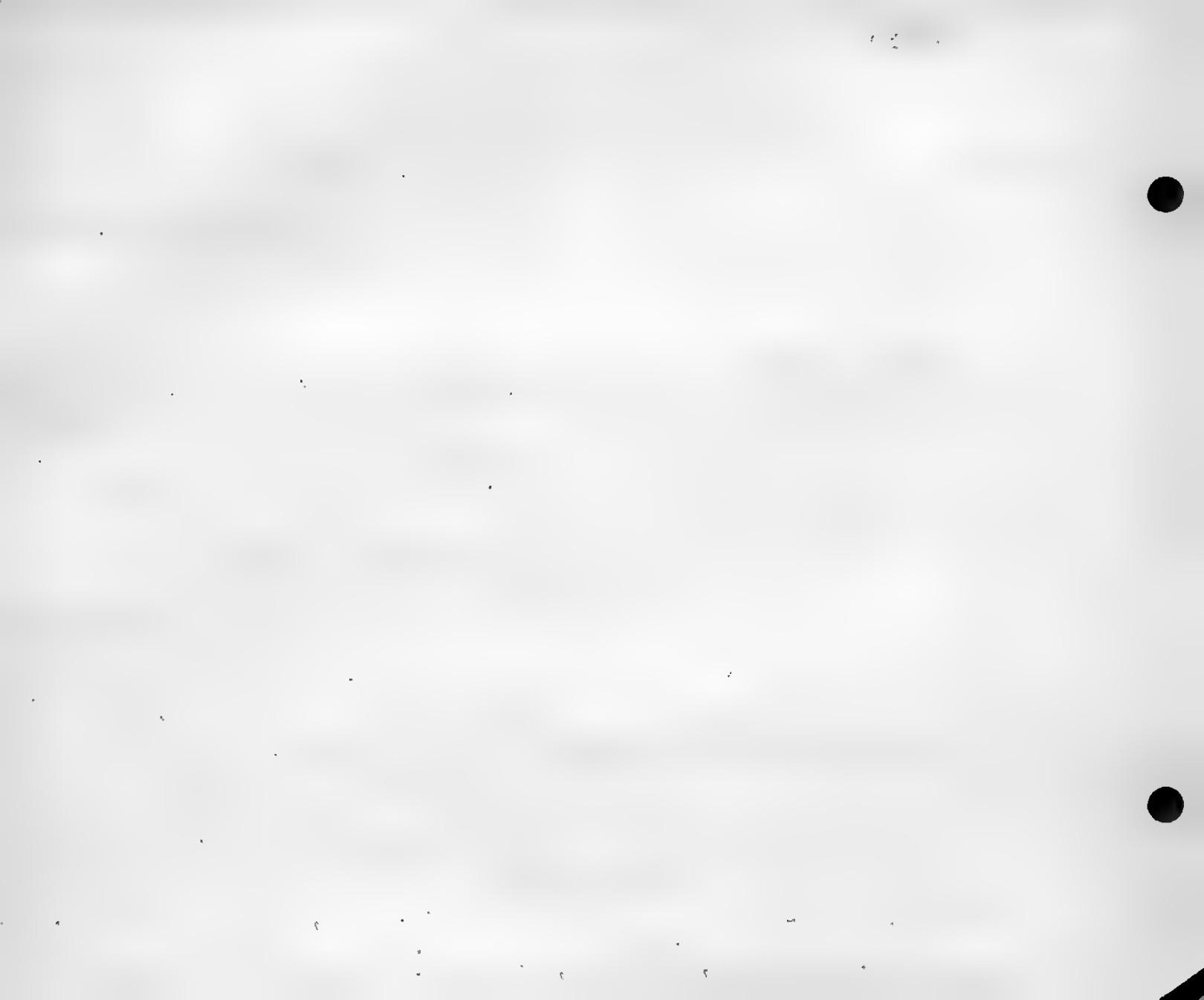
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05685

05680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)	First <i>Charles</i>	Middle <i>B.</i>	Last <i>Mitchell</i>	2a DATE KNOWN OF ESTI. DEATH MATED Month Year	Month <i>4</i>	Day <i>6</i>	Year <i>1969</i>	2b HOUR <i>11:30 AM</i>	
3 SEX <i>M.</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH <i>2/14/50</i>	6 AGE (In years last birthday) <i>19 YRS</i>	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURLY MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR <i>11:30 AM</i>		
7a BIRTHPLACE (State or foreign country) <i>Penn</i>	7b CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>	10 CITY OR TOWN OF DEATH <i>Gaithersburg</i>					
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>108 Brooks Ave.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Worker</i>			12b KIND OF BUSINESS OR INDUSTRY <i>AT&T Comm.unications</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b COUNTY <i>Montgomery</i>	13c CITY OR TOWN <i>Gaithersburg</i>	13d INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>108 Brooks Ave.</i>					
14. FATHER'S NAME First <i>Donald</i>	Middle <i>C</i>	Last <i>Mitchell</i>	15 MOTHER'S MAIDEN NAME First <i>Mary C</i>	Middle <i>Burnett</i>	Last <i>Siddon</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b SOCIAL SECURITY NO (If yes give war or dates of service) <i>184-40-7259</i>	17 INFORMANT <i>Mather (Mrs George Linton St. Anthony)</i>	ADDRESS <i>16 w. Stein Rd. S.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gun. Shot - wound of chest.</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Self-inflicted -</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?				
19c. MEDICAL CERTIFICATION					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>Shot - self in left chest with Rifle</i>	21b TIME OF INJURY Month, Day, Year HOUR <i>1125 PM April 6 1969</i>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Shot - self in left chest with Rifle</i>							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <i>Running House</i>	21e PLACE OF INJURY (At home, farm, street, factory, off ce building, etc.)	21f. LOCATION Street or R.F.D. No. <i>108 Brooks Ave</i>	City or Town <i>Gaithersburg</i>	County <i>Montgomery</i>	State <i>Md</i>				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John G. Ball</i>									
EXAMINER'S NAME (Type)									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>4-7-69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Johnson Chapel Cemetery, **</i>	23d. LOCATION (City or Town) <i>Fayette Co. Pa.</i>	(County) <i></i>	(State) <i></i>	22b. DATE SIGNED <i>April 7, 1969</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>	25a. ADDRESS <i>7557 Wisconsin Ave.</i>	25b. REC'D BY REG STRR <i>APR 15 1969</i>	25b. REGISTER'S SIGNATURE <i>Charles J. Doyle</i>						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 24A3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05686

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05686

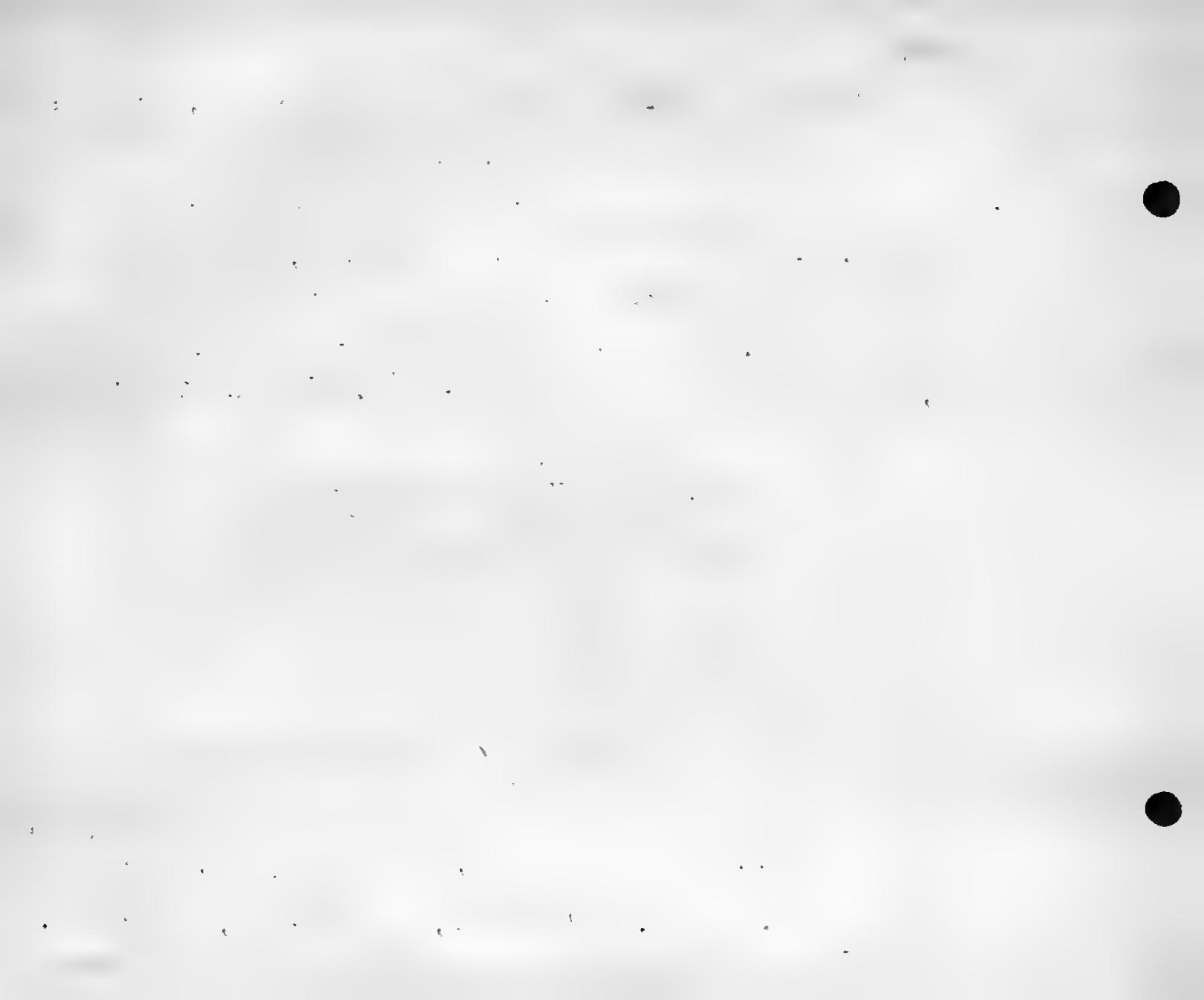
1. DECEASED NAME (Type or Print)			First Raymond	Middle C.	Last Moore	2a DATE KNOWN OF DEATH ESTIMATED MATED	Month 4	Day 22	Year 1969	2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 12-13-09	6 AGE (in years at birthday) 59 YRS	7 IF UNDER MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month 4 - Day 22 Year 1969				
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital 1113 Spotswood Dr.)			12a USUAL OCCUPATION (Kind of work done during last of working life, even if retired) Auditor			12b KIND OF BUSINESS OR INDUSTRY Pepco	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13c CITY OR TOWN Montgomery			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1113 Spotswood Dr.	
14 FATHER'S NAME James			15 MOTHER'S MAIDEN NAME E. Moore			16 Annie			17	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOC. SECUR. NO 577-05-0171			17. INFORMANT Mrs. Elaine L. Moore			ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Esphyxiation due to</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hanging</i> (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Depression</i>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year Hour A.M. P.M. 4-22-69			21c HOW INJURY OCCURRED (Enter notation only in Part 1 or Part 2 Item 18) <i>Decapitated, Repressed, Hunged self in basement, hanged</i>			21d. LOCATION Street or R.F.D. No City or Town (above) Silver Spring Montg. Md.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No City or Town (above) Silver Spring Montg. Md.			21g. County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Belden R. Beaps</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) BELDEN R. BEAPS, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a BURIAL CREMATION REMOVAL (Specify) Burial			23b DATE 4-25-69			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Francis J. Collins			ADDRESS 500 University Blvd. W., Silver Spring, Md.			25a. REG'D BY REGISTRAR MAY 25 1969			25b. REGISTRAR'S SIGNATURE <i>Charles J. Collins</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

05682

1. DECEASED-NAME (Type or print) BERTHA			Middle BELLE	Last MORRIS	2d. DATE OF DEATH Month April Day 15 , Year 1969	2d. HOUR 3:00
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH 6-22-80	6. AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburb Brn.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife.		12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 54 GREENE ST.		
14. FATHER'S NAME First Adam	Middle E.	Last BOSTON	15. MOTHER'S MAIDEN NAME First MARY	Middle E.	Last H. DEBRANDT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 6012 51120 00	17. INFORMANT ELIZABETH PARKER - DAUGHTER	Address BETHESDA, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Age - Decrement						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1-2, 1969 , to 4-14, 1969 , that (I) (we) last saw the deceased alive on 4-14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE W.T. Joyce		M.D. DEGREE W.T. Joyce	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED April 15, 1969
22d. PHYSICIAN'S NAME (Type) W.T. Joyce	22e. ADDRESS 4977 Battery Lane, Bethesda					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/17/69	23c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Cemetery	23d. LOCATION (City or Town) Cumberland, Allegany	(County) Md.	(State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home	ADDRESS 1331 Rock Pike Rockville, Maryland	25a. REC'D. BY REGISTRAR APR 21 1969	25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If necessary, attach a separate sheet of paper and attach to this page. This page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
05688MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05683

1. DECEASED-NAME (Type or print)	First HARRY	Middle LEO	Last MORRIS, JR.	2a. DATE OF DEATH Month APRIL	Day 7	Year 1969	2b. HOUR 11:45 P.M.
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH 24 JANUARY 1926		6. AGE (In years last birthday) 43 YRS	IF UNDER 1 YEAR 2 MONTHS	IF UNDER 24 HRS 7 DAYS	IF UNDER 24 HRS 11 HOURS
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. ARMED FORCES	12b. KIND OF BUSINESS OR INDUSTRY USMC		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5355 POOK HILL RD.			
14. FATHER'S NAME First HARRY	Middle LEO	Last MORRIS	15. MOTHER'S MAIDEN NAME First LETHA	Middle E.	Last PAYNE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES	16b. SOCIAL SECURITY NO WWII, KOREA, RVN 571-22-8349	17. INFORMANT (WIFE) MRS. CAROLYN ANNE MORRIS	5355 POOK HILL ROAD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Paraplegia DUE TO, OR AS A CONSEQUENCE OF Spinal cord transection with (c) Fragmentation wounds of back							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. Feb 28 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Wound to back during rocket attack				
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State Marine Corps Base Viet Nam				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10 MARCH 1969 to 7 APRIL 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 APRIL 1969 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>D. L. Colgan</i>		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 10 April 1969		
22d. PHYSICIAN'S NAME (Type) D. L. COLGAN M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND					
23a. BURIAL, CREMATION, BURIAL (Specify) Burial	23b. DATE 4-14-69	23c. NAME OF CEMETERY OR CREMATORIAL Fort Rosecrans National Cem. San Diego	23d. LOCATION (City or Town) (County) (State) Calif.				
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin St., N.W. Washington, D. C.		ADDRESS	25a. REG'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE <i>Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05689

CERTIFICATE OF DEATH

05684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First WILLIAM	Middle JACK	Last MORRIS	2a. DATE OF DEATH Month 4 Day 2 Year 69	2b. HOUR 8:30A M	
3. SEX MALE		4 RACE WHITE	5. DATE OF BIRTH 9-13-00		6 AGE (in years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY MONTG. COUNTY	
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CLARKSBURG	13d. INSIDE CITY L M TS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER ROUTE #2	
14. FATHER'S NAME First SEBERT		Middle -	Last MORRIS	15. MOTHER'S MAIDEN NAME First CLEMENTINE		Middle -	Last KNIGHT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 219-34-8844		17. INFORMANT MEDICAL RECORD DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Carcinoma of rectum</i> unresected DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>with generalized metastases</i> (b) <i>due to, or as a consequence of</i> (c) <i>due to, or as a consequence of</i> </p>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <p><i>Pulmonary infarct</i></p>							
19a. DATE OF OPERATION 3/24/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of rectum		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 3/23 , 19 69 , to 4/2 , 19 69 , that (I) (we) last saw the deceased alive on 4/2 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur F. Woodward</i>		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4/2/69	
22d. PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD, M. D.		22e. ADDRESS 115 NORTH VANBUREN ST., ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-69	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Grove Church		23d. LOCATION (City or Town) Quince	(County) Greene	(State) Va.
24. FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS Gaithersburg, Md.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
			DATE APR 7 1969				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05690

05685

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM		
				May	Helen	Morrissey	4	14	69	5:30 AM		
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years lost b/rthday)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White		11-28-90			78 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
N.Y.		American		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Montgomery			Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Wash. San. + Hosp.				Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		Residence before		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Md.		Montgomery		Rockville		<input checked="" type="checkbox"/>		12104 Hitching Post Lane				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	Address		
John		H.	Kelly		Margaret		McDonald					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOC. SEC. NUMBER (If yes give war or dates of service)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No				Unknown		Tuberculosis				Today		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF		C.H.F				4 day		
		(c)		DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION				19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at office <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 4/13, 1969, to 4/14, 1969, that (I) (we) last saw the deceased alive on 4/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		R.H. Sandstrom MD		DEGREE		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 4/14/69			
22d. PHYSICIAN'S NAME (Type)		R.H. Sandstrom MD		22e. ADDRESS		7701 Carroll Ave Takoma Park, Md						
23a. BURIAL, CREMATION, REMOVAL (See 24b)		23b. DATE 4-14-69		23c. NAME OF CEMETERY OR CREMATORIAL St. Agnes Cemetery		23d. LOCATION (City or Town) Syracuse,		County New York		(State)		
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

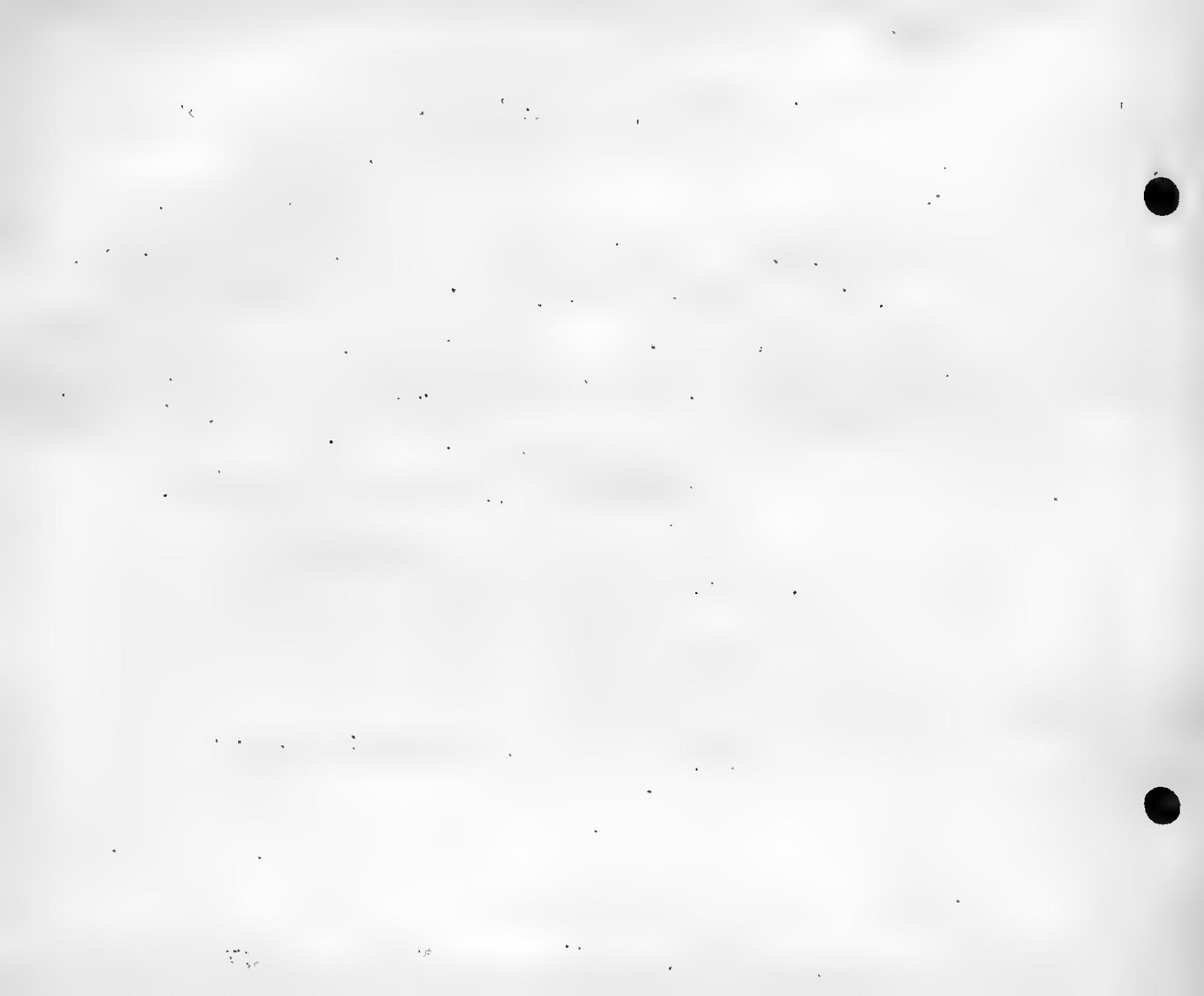
05691

05686

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM	
<i>ANTHONY J.</i>		<i>MOSCHETTO</i>		4	9	69	6 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
<i>Male</i>	<i>White</i>	<i>10-26-17</i>		<i>51</i> YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		Md.		
<i>D.C.</i>		<i>U.S.A.</i>		<i>MONTGOMERY</i>		<i>newspaper</i>		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Silver Spring</i>	<i>Holy Cross</i>			<i>RETIRED</i>			<i>newspaper</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
<i>Md.</i>	<i>MONTGOMERY</i>	<i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	<i>709 VENICE DR.</i>					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<i>NUNZIO J. MOSCHETTO</i>				<i>LENETA LUPA</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or Unknown	16b. SOCIAL SECURITY NO	17. INFORMANT	Address					
<i>YES</i>	<i>519-10-6169</i>	<i>Mrs. MOSCHETTO</i>	<i>13a b, c, d & e above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <i>Maurice acute pulmonary edema</i> Hours <i>412 2</i>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) <i>Hypertensive cardiovascular disease</i> Years <i>stating the underlying cause</i>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
<i>Portal venous liver</i>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
	<i>19</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 1, 1969</i> to <i>APRIL 2, 1969</i> , that (II) (we) last saw the deceased alive on <i>APRIL 1, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Albert H. Grollman M.D.</i>								
22c. DATE SIGNED <i>4/9/69</i>								
22d. PHYSICIAN'S NAME (Last, First, Middle Initial)	22e. ADDRESS <i>106 SPRING ST. - SILVER SPRING</i>							
<i>ALBERT H. GROLLMAN</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town)	(County)		(State)		
<i>Burial</i>	<i>12 APR. 1969</i>	<i>FORT LINCOLN CEMETERY</i>	<i>BLADENSBURG, MD.</i>					
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
<i>LINALDI FUNERAL HOME, INC.</i>	<i>7400 GEORGIA AVE. N.W. DC 20012</i>			<i>APR 11 1969</i>	<i>Albert H. Grollman</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05692

05687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. If Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/or any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <u>William</u>	Middle <u>R.</u>	Last <u>Moulden Jr.</u>	2a. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1969</u>	2b. HOUR Hour <u>9 A.M.</u>
3. SEX <u>Male</u>		4 RACE <u>White</u>	5. DATE OF BIRTH <u>5/21/09</u>		6. AGE (In years last birthday) <u>59</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN <u>0</u>
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u>	
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hosp.</u>		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if ret'd.) <u>Executive</u>		12b. KIND OF BUSINESS OR INDSTRY <u>Patelaw</u>
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) <u>Maryland</u>		13b. CITY OR TOWN <u>Montgomery Bethesda</u>	13c. INSIDE CITY, IN TOWNSHIP <u>YES</u>	13d. STREET AND NUMBER <u>5030 Allandria</u>		
14. FATHER'S NAME First <u>William</u> Middle <u>L.</u> Last <u>Moulden Jr.</u>		15. MOTHER'S MAIDEN NAME First <u>Marian</u> Middle <u>H.</u> Last <u>Stewart</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>Yes, Marines</u>		16b. SOCIAL SECURITY NO <u>577-07-4137</u>	17. INFORMANT <u>Mary G. Moulden (Wife)</u>	Address <u>Same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>1949</u> , to <u>16 April</u> , 1969, that (I) (we) last saw the deceased alive on <u>15 April</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Merton L. White</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <u>16 April 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Merton L. White</u>		22e. ADDRESS <u>9911 Georges Creek Rd., Germantown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-18-1969</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Saint Paul's Church Cemetery - Ivy, Albemarle Co., Va.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SON, ADDRESS 5130 WISG. AVE., N. W. WASH., D. C. 20015</u>				25a. REC'D BY REG STRR. <u>APR 21 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, within 72 hours of death.

- 05693

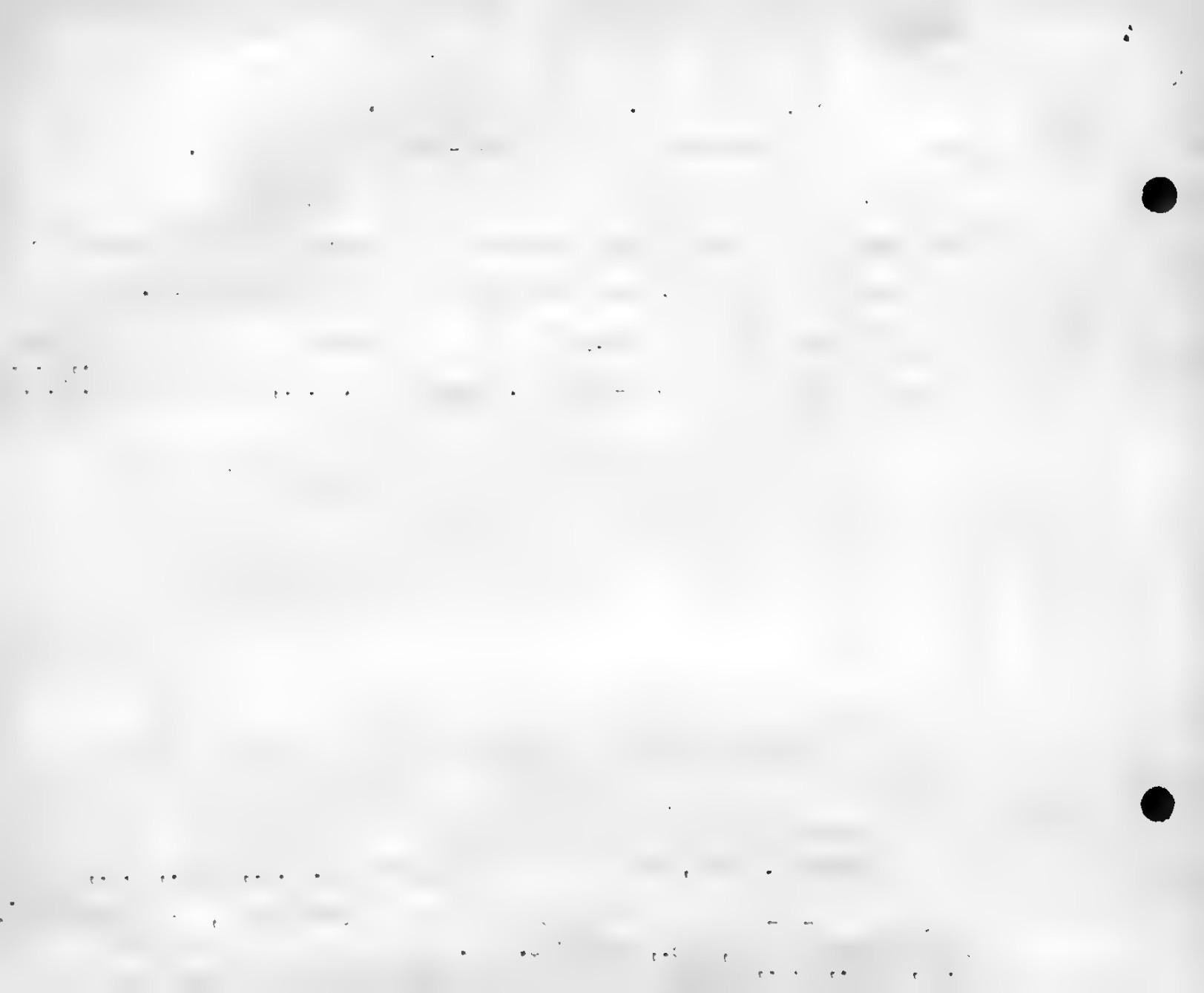
Item2 FilmG412 4/30/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05688

1. DECEASED-NAME (Type or print)		First Frank	Middle J.	Last Murphy	Sr.	2d DATE OF DEATH Month Day Year April 21 - 13 - 1969	2d HOUR 2:20 P.M.
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 8-5-1888		6. AGE (In years to birthday) 80 yrs., 8 mos.	
7a BIRTHPLACE (State or foreign country) New York		7b CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last 6 months) 4515 Willard Avenue #207		12a. USUAL OCCUPATION (Kind of work done during working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Contactor	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Patrick		Middle Murphy	Lost	15. MOTHER'S MAIDEN NAME First Nellie		Middle	Last Cooper
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No		16b. SOCIAL SECURITY NO 577-03-4108		17. INFORMANT Dr. Jerome Krick, M.D., 2800 Quebec St. N.W.		Address Wash., D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 402 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension & hypertension heart disease. DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus Pneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from 1950 to 4/13/1969 , that (I) (we) last saw the deceased alive on 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerome J. Krick, MD		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 4-14-69	
22d. PHYSICIAN'S NAME (Type) Jerome J. Krick, MD		22e. ADDRESS 2800 Quebec St. N.W., Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-16-1969		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) Colmar Manor, Prince Georges Co. (State) Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016		ADDRESS		25a. RECEIVED BY REGISTRAR DATE APR 18 1969		25b. REGISTRAR'S SIGNATURE James George	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Other pages may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												05694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH		05689	
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2e. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- MATED <input type="checkbox"/> April 13 1969		2b. HOUR 12 PM	
3. SEX 7 e.			4. RACE white			5. DATE OF BIRTH Dec. 23, 1877			6. AGE (In years Anthony) 81 yrs			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			2c. DATE PRONOUNCED DEAD Month April Doy 13 Year 1969		2d. HOUR 12 PM	
10. CITY OR TOWN OF DEATH Wheaton						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Reside before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Wheaton			13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13121 Holdridge Road				
14. FATHER'S NAME (unknown)						15. MOTHER'S MAIDEN NAME N Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO 216-46-6181			17. INFORMANT Edward Hall Musson, Jr., 13121 Holdridge Rd.		ADDRESS Wheaton, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY. IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency Aorta					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 o' clock				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4124						(b) DUE TO, OR AS A CONSEQUENCE OF Cardiovascular Disease					years 5				
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture of Left Humerus -															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P. M. 4 7 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Fall at home causing fracture of Left Humerus						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home -			21f. LOCATION Street or R.F.D. No. - City or Town - County - State -						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John S. Ball</i>						M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) John S. Ball									ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 16, 1969			23c. NAME OF CEMETERY OR CREMATORIAL St. Lincoln Cemetery			23d. LOCATION (City or Town) Bladensburg, Maryland		(County)		(State)		
24. FUNERAL DIRECTOR Glen Carter King Gates 8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.						ADDRESS			25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones				



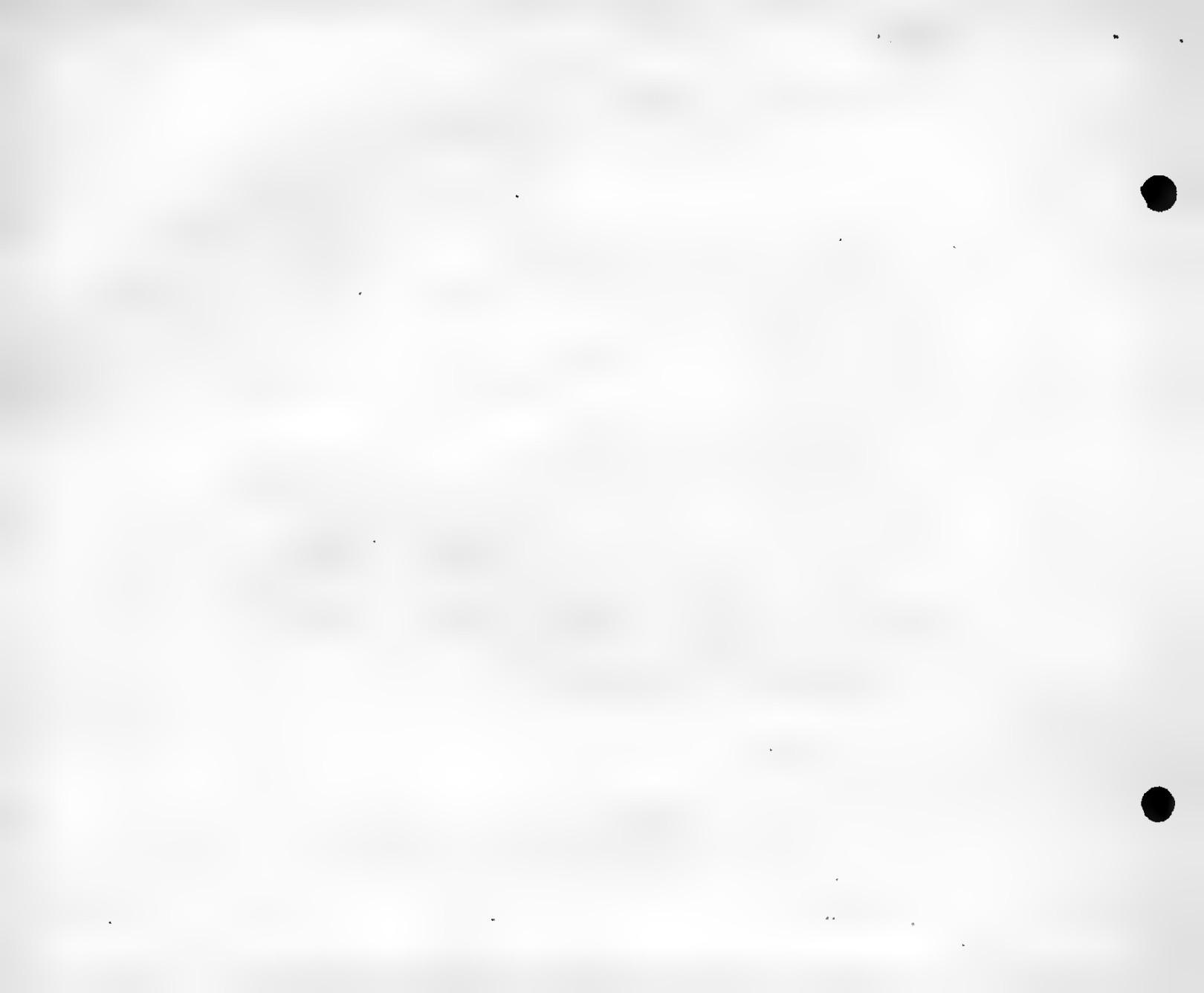
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05690

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
John Milton Nagel						4	29	Day	Year	8:25 AM	
3. SEX	4. RACE				S. DATE OF BIRTH	6 AGE (In years last birthday)			IF UNDER 1 YEAR	IF UNDER 24 HRS	
male	white				6-28-09	59 yrs			MONTHS	MONTHS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH				
Pa		U.S.A.		WIDOWED		<input type="checkbox"/> DIVORCED	Montgomery				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Hosp.			Printer			G.P.O.		
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Prince Georges md			Riverdale			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5313 Riverdale Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Carl					Nagel	Pearl					Gray
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			VIRGINIA, NAGEL Same as Address #13		
no						Hospital chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>left respiratory</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma, left kidney</u> .											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hours. 2-0 hours. unknown.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
4-28-69		carcinoma, left kidney.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> , 19 <u>69</u> , to <u>4-29</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>4-28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Serial T. Kimble, M.D.</u>											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			ATTENDING PHYS		<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22f. DATE SIGNED <u>4-29-69</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CINERATOR		23d. LOCATION (City or Town) County		(State)			
BURIAL		May 2, 1969		Cedar Hill Cem.		Sutherland		Maryland			
24. FUNERAL DIRECTOR		ADDRESS			24d. RECD. BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
W.W. Chambers Co		Riverdale Md			MAY 2 1969		Official as Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05696

05691

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>ROBERT</i>	Middle <i>T.</i>	Last <i>NEWMAN</i>	2a. DATE OF DEATH Month <i>4</i>	Day <i>-2</i>	Year <i>1969</i>	2b. HOUR <i>22</i>						
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>6/30/11</i>			6. AGE (In years last birthday) <i>57</i>		IF UNDER 1 YEAR MONTHS <i>10</i>		IF OVER 24 HRS. DAYS <i>02</i>		HOURS <i>00</i>			
7a. BIRTHPLACE (State or foreign country) <i>VA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>MONTGOMERY</i>										
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Truck Driver</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>1150 7600 Old 100 Rd.</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>MD.</i>		13c. CITY OR TOWN <i>MONTGOMERY S.S.</i>			13d. INS. OR CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>1150 7600 Old 100 Rd.</i>							
14. FATHER'S NAME First <i>Thomas</i>		Middle <i>Newman</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Rosa</i>		Middle	Last <i>Humphrey</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <small>(Type name or dates of service) <i>WWII</i></small>		16b. SOCIAL SECURITY NO <i>705 01 6153</i>			17. INFORMANT <i>Maxine L. Newman-wife-same item # 13</i>			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lobar pneumonia.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4d</i>														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Multiple old myocardial infarction</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-27</i> , 19 <i>69</i> , to <i>4-2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-2</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>J. W. Wheeler</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>4-2-69</i>								
22d. PHYSICIAN'S NAME (Type) <i>ABRAHAM W. DANISHT</i>		22e. ADDRESS <i>1106 SPRINGS ST SS</i>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/7/69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>			23d. LOCATION (City or Town) <i>Baltimore, Maryland</i>		(County)		(State)			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		ADDRESS <i>1991 Rock Pike</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
VR APR 30M REV. 1968					APR 7 1969									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05697

CERTIFICATE OF DEATH

05692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers, and in any event, within 72 hours, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours.

1. DECEASED NAME (Type or print)	First Dorothy	Middle Orrienne	Last Newton	2d. DATE OF DEATH Month April	Day 21	Year 1969	2b. HOUR P 11:30 M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 15 January 1909			6. AGE (In years lost birthday) 60	IF UNDER 1 YEAR MONTHS 3	IF UNDER 24 HRS. DAYS 6	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Montgomery			Md.			
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Connecticut	13b. COUNTY Hamden	13c. CITY OR TOWN Hamden	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER # 11 Ridgewood Avenue					
14. FATHER'S NAME First Edwin	Middle Raymond	Last Brackett	15. MOTHER'S MAIDEN NAME First Evelyn	Middle Mandell	Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17. INFORMANT The Medical Records Address not available The Clinical Center, NIH, Bethesda, Maryland			20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4124					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o). stating the underlying cause { Idiopathic Thrombocytopenic Purpura					6 years				
DUE TO, OR AS A CONSEQUENCE OF (b) last. (c) Right-sided Cardiovascular Accident									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 15 April , 19 69 , to 21 April , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 21 April 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <i>Arthur H. Weintraub M.D.</i>									
22c. DATE SIGNED 22 April 1969									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland							
23a. BURIAL/CREMATION/ REMOVAL (Specify)		23b. DATE 4-29-69	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Noodland Cemetery			23d. LOCATION (City or Town) Coventry	(County) R. I	(State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557-Wisconsin Ave., Bethesda, Md.		ADDRESS			25a. REC'D BY REGISTRAR DATE APR 28 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05693

hours after death.

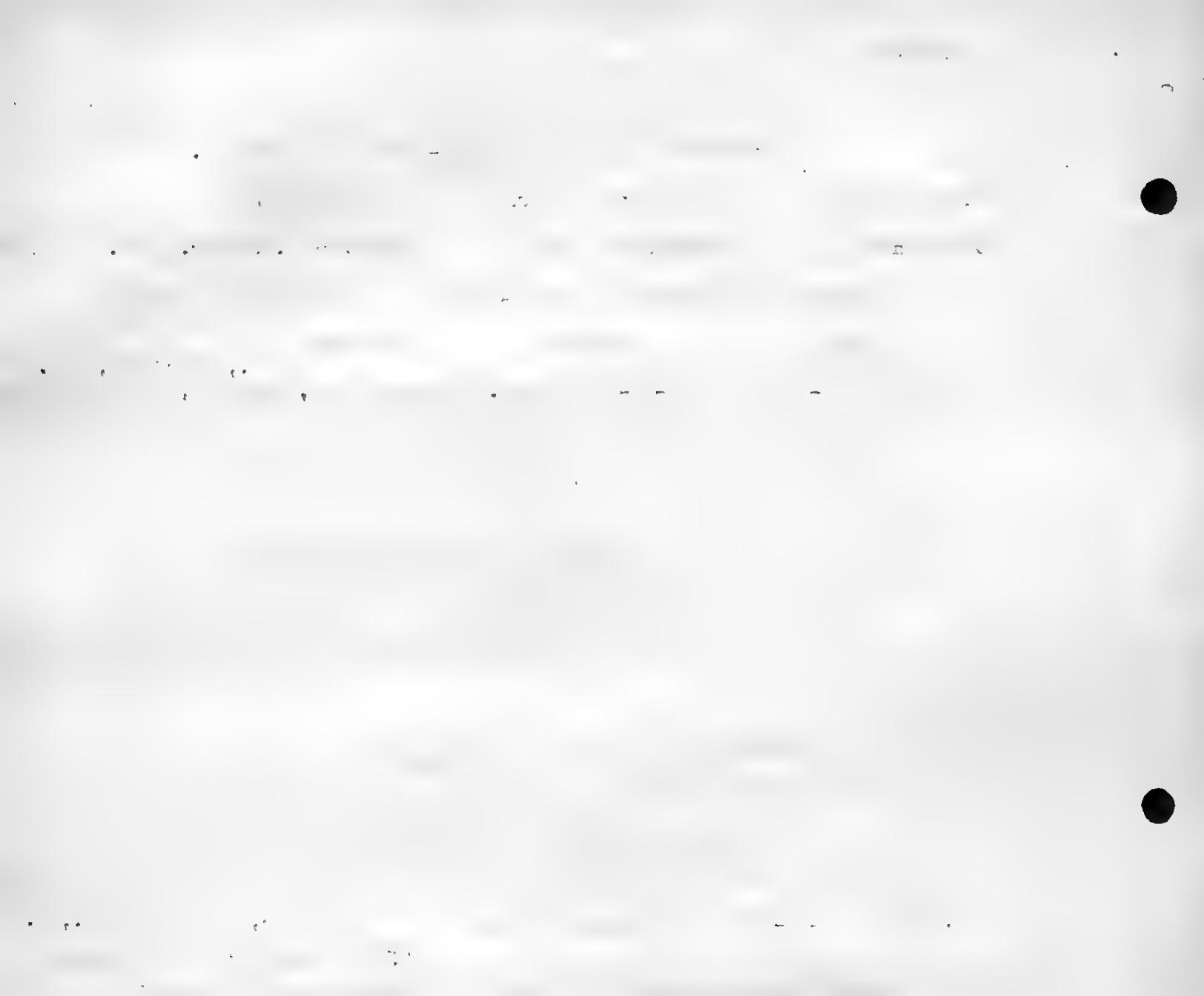
I, James T. Nicholson, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First JAMES T	Middle NICHOLSON	Last	2a. DATE OF DEATH Month APRIL Day 15 Year 1969		2b. HOUR 11:55 AM					
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH 10-31-1893		6. AGE (In years at death) 75 yrs		7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS MONTHS 0	9. IF UNDER 24 HRS DAYS 0	10. HOURS 0	11. MIN	
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery							
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) 4906 Essex Avenue		12a. USUAL OCCUPATION (Kind of work done during working hours) Executive Vice Pres. Amer. Red Cros		12b. KIND OF BUSINESS OR INDUSTRY Rd. Add Dearfield, Ill.						
13a. JSUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 4906 Essex Avenue						
14. FATHER'S NAME First Joseph		Middle Nicholson	Last	15. MOTHER'S MAIDEN NAME First Elizabeth		Middle	Last Ayers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO. WW - 1 579-44-5484		17. INFORMANT Mrs. Elizabeth Fish, Daughter, 1446 Windcrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs						
18. CAUSE OF DEATH (Enter on a line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Rupture Abdominal Aneurysm 441.2 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema Chronic Bronchitis												
MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
				<input type="checkbox"/> YES <input type="checkbox"/> NO								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>If either, notify medical examiner</small>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (This hospital) attended the deceased from Feb 4, 1951 , to April 15, 1969 , that (I) (we) last saw the deceased alive on April 15, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Theodore J. Abernethy		MD DEGREE		ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED 4-16-69			
22d. PHYSICIAN'S NAME (Type) Theodore J. Abernethy		22e. ADDRESS 916-19½ St. N.W. Washington D.C.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-18-1969		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, Montgomery Co., Md.		(County)		(State)		
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.		ADDRESS 5130 WISC. AVE., N. W. WASH. D. C. 20015		25a. RECD BY REGISTRAR DATE APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05699

05694

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, places 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Katherine</i>	Middle <i>C.</i>	Last <i>Nichter</i>	2a. DATE OF DEATH Month <i>April</i>	Day <i>17</i>	Year <i>1969</i>	2b. HOUR <i>5:15 P.M.</i>
3. SEX <i>Female</i>	4 RACE <i>White</i>	S. DATE OF BIRTH <i>12-31-95</i>	6. AGE (In years last birthday) <i>73 yrs.</i>	7e. BIRTHPLACE (State or foreign country) <i>Ca.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>MONTGOMERY CO.</i>
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Resident cafeteria Mar.</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Resident cafeteria Mar.</i>				
13a. JSJAL RESIDENCE (Where deceased admission) STATE <i>MD.</i>	13b. CITY OR TOWN <i>MONTGOMERY SILVERSPP.</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>611 Rosemead St.</i>				
14. FATHER'S NAME First <i>H. Robert Steed</i>	Middle	Last	15. MOTHER'S MAIDEN NAME First <i>Cora</i>	Middle <i>(unknown)</i>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <i>(Son)</i>	Address <i>H. Robert Nichter-742 Miller Ave., Great Falls Va.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal Obstruction</i> DUE TO, OR AS A CONSEQUENCE OF Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Adhesions peritoneal cavity</i> DUE TO, OR AS A CONSEQUENCE OF (b) (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Malignant Lymphoma, paraaortic area</i>						Unknown	
19a. MEDICAL CERTIFICATION DATE OF OPERATION <i>4-16-69</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal obstruction</i>	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>cpa</i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>Nov. 1968</i> , to <i>Sept 18, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 18, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.						22c. DATE SIGNED <i>April 19, 1969</i>	
22b. SIGNATURE <i>Aaron H. Traum</i>	22d. DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	22e. ADDRESS <i>8237 Georgia Ave - Silver Spring Maryland</i>	22f. STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Apr. 22, 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>George Washington Cem.</i>	23d. LOCATION (City or Town) <i>Hyattsville, Maryland</i>	(Country) <i>Maryland</i>	(State)		
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc. Silver Spring, Md.</i>	25a. RECEIVED BY REGISTRAR DATE <i>APR 24 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Frances Justice</i>					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~executed~~ within 24 hours after death.

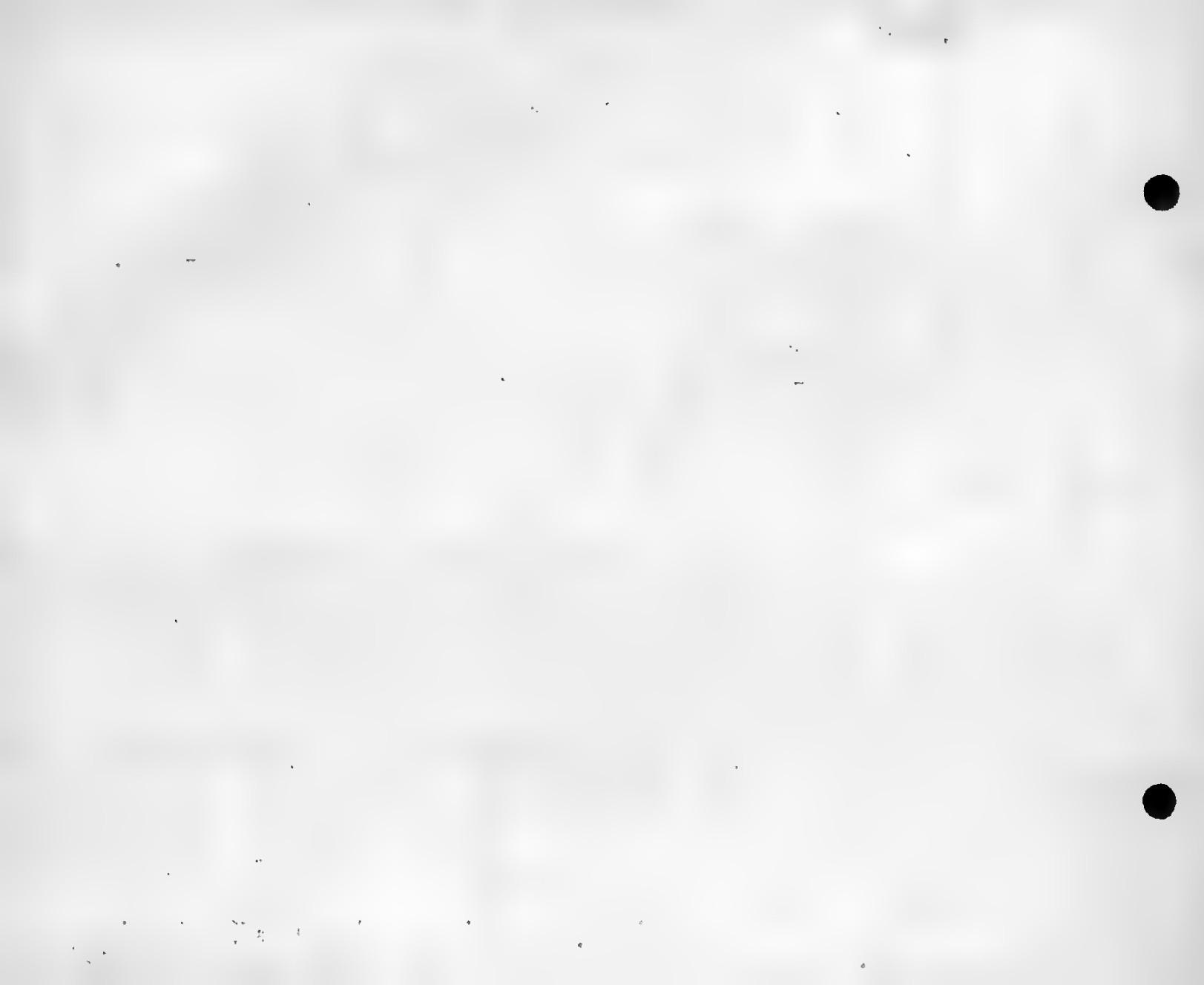
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Roger and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05695

1. DECEASED NAME (Type or print)	First <i>CHARLES William Nasko</i>	Middle	Last	2a. DATE OF DEATH Month 4	Day 4	Year 1969	2b. HOUR 10 AM	
3. SEX <i>MALE</i>	4. RACE <i>Cauc.</i>	5. DATE OF BIRTH <i>6-22-73</i>		6. AGE (In years last birthday) <i>95</i>		IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>AMERICAN</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Takoma Park Washington D.C. & Hsp</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ins. Salesman</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Prince George</i>	13c. CITY OR TOWN <i>Beltsville</i>	13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>13101 Lucy Drive</i>				
14. FATHER'S NAME First <i>Charles</i>	Middle <i>Nasko</i>	Last	15. MOTHER'S MAIDEN NAME First Middle Last <i>? Rose ?</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No <i>No</i>	16b. SOCIAL SECURITY NO. <i>577-05-7535 Chart</i>	17. INFORMANT <i>Chart</i>	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Probable Asystole</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Generalized aging</i> several years (b) <i>Acute cytotoxicis</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Y</i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II Item 18) <i>shot</i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at office <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>April 3, 1969</i> , to <i>April 4, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 4, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.								
22b. SIGNATURE <i>Edw. Neary, M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>April 5, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>EINe MAGI</i>	22e. ADDRESS <i>831 Quince Blvd. E., Silver Spring, Md.</i>							
23a. BURIAL, CREMATION BURIAL <input type="checkbox"/> Cremation <input type="checkbox"/>	23b. DATE <i>4/8/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln Cem.</i>	23d. LOCATION (City or Town) <i>Colmar Manor, Md.</i>	(County) (State)				
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.	25a. ADDRESS <i>Mt. Rainier, Maryland</i>	25b. REC'D BY REGISTRAR <i>APR 10 1969</i>	25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15 45M								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Power Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05701

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05696

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF EST. DEATH MATED	Month	Doy	Year	2b HOUR	
<i>Matthew Harry Novak</i>					<input checked="" type="checkbox"/>	4-4-	19	815	A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years at birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONONCED DEAD Month Day Year			2d HOUR	
Male	Cauc	Feb. 8, 1903	86 yrs			4	4	69 815	A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
<i>Penns.</i>		<i>U.S.A.</i>				<i>Montgomery</i>			Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJAL OCCUPATION (Kind of work done most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
<i>Wheaton</i>		<i>Univer. Hospt. Home</i>		<i>Buckley</i>						
13c. USJAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?		13e STREET AND NUMBER				
<i>D.C.</i>		<i>WASH.</i>		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<i>336 Md. Ave., N.E.</i>				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
<i>UNKNOWN</i>					<i>UNKNOWN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
<i>No</i>		<i>589093532</i>		<i>BERNARD J. NOVAK</i>		<i>724 N. 23rd St.</i>			<i>PHILADELPHIA, PA.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Metastatic Adenocarcinoma</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1621</i> Conditions, if any, wh ch gave rise to immediate cause (a), stating the <u>underlying cause</u> last		<i>of Lung</i>								
(b)										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED
ACTUAL SIGNATURE		<i>Belden R. Peep</i>								<i>APRIL 4, 1969</i>
EXAMINER'S NAME (Type)		<i>BELDEN R. PEPP, M.D., Wheaton</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Board				23d. LOCATION (City or town) (County) <i>Georgetown Medical School</i> (State) <i>3rd floor Georgetown Rd NW Wash DC</i>		
<i>4-11-1969</i>		<i>Chesapeake Board</i>								
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG STAR		25b. REGISTRAR'S SIGNATURE				
<i>Wm. Chambers Coyle Silver Spring Md.</i>				<i>APR 15 1969</i>		<i>Clarence Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First KERRY	Middle JOANN	Last NYGREN	20. DATE OF DEATH APRIL 8th 8 Day 1969	2b. HOUR 3:38AM
3. SEX FEMALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MAY 23, 1955		6. AGE (In years lost birthday) 15	7. UNDER 24 HRS MONTHS YRS.
7. BIRTHPLACE (State or foreign country) NEBRASKA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most recent year, even if retired) STUDENT	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE VIRGINIA	13b. COUNTY FAIRFAX	13c. CITY OR TOWN VIENNA	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 1410 CARRINGTON LANE	
14. FATHER'S NAME First HARLEY	Middle D.	Last NYGREN	15. MOTHER'S MAIDEN NAME First NORMA	Middle M.	Last GROBEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No	16b. SOCIA. SECURITY NO. N/A	17. INFORMANT FATHER HARLEY D. NYGREN	1410 CARRINGTON LANE, VIENNA, VIRGINIA 22180		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) ACUTE LARYNGOTRACHEOBRONCHITIS PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) with BILATERAL BRONCHOPNEUMONIA					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 Hours					
<p>170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) _____ DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____ DUE TO, OR AS A CONSEQUENCE OF</p>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that XX (this hospital) attended the deceased from April 6, 1969 , to April 8, 1969 , that (I) (we) last saw the deceased alive on April 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) (did) XX view the body after death.					
22b. SIGNATURE 					
22d. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, CDR MC USN		22e. DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8 April 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 11, 1969	23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park Falls Church, Fairfax, Va	23d. LOCATION (City or Town) Falls Church, Fairfax, Va	(County) Fairfax	(State) VA
24. FUNERAL DIRECTOR J. M. Jackson	25a. DATE APR 11 1969	25b. REG'D BY REGISTRAR PEARSON'S FUNERAL HOME Falls Church, Virginia	25c. CO-REGISTRAR OR SIGNALER George J. Pearson		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05698

1
15703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Lucy</i>	Middle <i>A.</i>	Last <i>NYLEN</i>	2d. DATE OF DEATH Month <i>April</i>	Day <i>17</i>	Year <i>1969</i>	2b. HOUR <i>4:45 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>1/16/85</i>		6. AGE (In years last birthday) <i>34 yrs</i>		IF UNDER MONTHS YEARS		
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		9. COUNTY OF DEATH <i>Montgomery</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Ret. Sales Lady</i>		13a. USUAL RESIDENCE (Where deceased lived, if instituton or address on) STATE <i>Maryland</i>		13c. CITY OR TOWN <i>Holtsville</i>	
14. FATHER'S NAME First <i>Breckley</i>		Middle <i>Hornev</i>	Last <i>(Lorraine)</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Son</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>2333 New Hampshire Ave</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>256-16-0771</i>		17. INFORMANT <i>Daughter - Ira & Nylene</i>		Address <i>Same as above</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>4101</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>MYOCARDIAL INFARCTION, ACUTE</i>		CIRCULATORY COLLAPSE					
stating the underlying cause lost.		(c) <i>ARTERIOSCLEROTIC HEART DISEASE 10+YRS</i>				6 DAYS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>CONGESTIVE HEART DISEASE - DIVERGICULOSIS</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , to <i>PRES</i> , that (I) (we) last saw the deceased alive on <i>16 APRIL 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Charles J. Savarese Jr.</i>		2d. DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/17/69</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>CHARLES J. SAVARESE, JR. MD 11,125 ROCKVILLE PIKE, ROCKVILLE, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 19, 1969</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) <i>Bladensburg, Maryland</i>		(County) <i>20752</i> (State)	
24. FUNERAL DIRECTOR <i>Glen Carter Caskets, 8434 Georgia Avenue</i>				25a. APRIL REGISTRAR <i>APR 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Warren E. Pumphrey, Inc. Silver Spring, Maryland</i>			



**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

172 Experiments on TETRA

1. DECEASED NAME (Type or print)		First <i>Nell</i>	Middle <i>G.</i>	Lost <i>O'Connell</i>	2d. DATE OF DEATH Month <i>April</i>	Day <i>10</i>	Year <i>1969</i>	2d. HOUR <i>?</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 29, 1896</i>		6. AGE (In years last birthday) <i>73</i>		F UNDER 1 YEAR MONTHS <i>YRS.</i>	F UNDER 24 HRS MONTHS <i>MONTHS</i>	F UNDER 24 HRS DAYS <i>DAYS</i>	F UNDER 24 HRS HOURS <i>HOURS</i>	F UNDER 24 HRS MIN <i>MIN</i>	
7a. BIRTHPLACE (State or foreign country) <i>Lincoln, Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Montgomery</i>							
10. CITY OR TOWN OF DEATH <i>Silver Spring, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1001 Spring St., S.S., Md.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Van home</i>							
13a. LSLAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>1001 Spring Street</i>					
14. FATHER'S NAME First <i>George</i>		Middle <i>Dowdle</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>(Unknown)</i>		Middle <i></i>	Last <i>McCarthy</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>?</i>		17. INFORMANT <i>Charles G. O'Connell, 8503 Mayfair Place,</i>		Address <i>Ste Sil. Spr., Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>		DUE TO, OR AS A CONSEQUENCE OF <i>Hypertension and coronary disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4100</i>		DUE TO, OR AS A CONSEQUENCE OF <i></i>				DUE TO, OR AS A CONSEQUENCE OF <i></i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>61</i> , to <i>April</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/15</i> 19 <i>69</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>James C. Mandes, M.D.</i>													
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>1631 16th St., NW</i>		22f. DATE SIGNED <i>4/10/69</i>									
23d. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23e. DATE <i>April 14, 1969</i>		23f. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>		23g. LOCATION (City or Town) <i>Washington, D.C.</i>		(County) <i></i>		(State) <i></i>			
24. ATTENDING DIRECTOR <i>C. Glen Carter</i>		ADDRESS <i>18434 Georgia Avenue</i>		25a. REG'D BY REC'D STAR <i>APR 17 1969</i>		25b. REG'D STAR'S SIGNATURE <i>James Judge</i>							
Warner E. Pumphrey, Inc. Silver Spring, Md.													



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please mail page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05705		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH						05100	
1. DECEASED-NAME (Type or print)		First <i>GEORGE W.</i>	Middle <i>O'KEEFE</i>	Last <i>O'KEEFE</i>	2a. DATE OF DEATH Month <i>April</i>		Doy <i>20</i>	Year <i>1969</i>	2b. HOUR <i>2:30 P.M.</i>
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>6/7/01</i>		6. AGE (In years last birthday) <i>67</i>		IF UNDER 1 YEAR MONTHS <i>YRS</i>	
7a. BIRTHPLACE (State or foreign country) <i>Colo.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery.</i>		IF UNDER 24 HRS MONTHS <i>DAYS</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Silver Spring Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>P.R.T. - ATTORNEY</i>		12b. KIND OF BUSINESS OR INDSTRY <i>LAW</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1604 Henderson St.</i>	
14. FATHER'S NAME First <i>PATRICK S.</i>		Middle <i>O'KEEFE</i>	Last <i>ROSE</i>	15. MOTHER'S MAIDEN NAME First <i>Rose</i>		Middle <i>-</i>	Last <i>-</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No.</i>		16b. SOCIAL SECURITY NO <i>578-10-4572</i>		17. INFORMANT <i>Richard Bass-Nephew</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>one</i>			
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cancer</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Anemia</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>liver and lung dysfunction</i>		4 days		4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cocaine & the Paroxysm - Part of hyperactive episode</i>									
19a. DATE OF OPERATION <i>15 Sept</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cocainoma & the Paroxysm</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>			
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner) <i>at work</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>at work</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Office Building, etc.</i>		21f. LOCATION Street or R.F.D. No <i>Street or R.F.D. No</i>		City or Town <i>City or Town</i>		County <i>County</i>	State <i>State</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>6-4-67</i> , to <i>4-20-1967</i> , that (I) (we) last saw the deceased alive on <i>4-17-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>William H. Killay MD</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>4-20-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>WILLIAM H. KILLEY</i>		22e. ADDRESS <i>5218 W. 36th Ave., BETH. MD.</i>							
23a. BUR. A. CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-23-69</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL CEM.</i>		23d. LOCATION (City or Town) <i>SUITLAND, MD.</i>		(County) <i>(County)</i>	(State) <i>(State)</i>
24. FUNERAL DIRECTOR <i>JOS. GAWER'S SONS, 5130 WISCONSIN AVE. WASHINGTON, D.C.</i>		ADDRESS <i>5130 WISCONSIN AVE. WASHINGTON, D.C.</i>		25a. RECEIVED BY REGISTRAR DATE <i>APR 23 1969</i>		25b. REGISTERAR'S SIGNATURE <i>JOHN J. KILLEY</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05706

05701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Nettie</i>	Middle <i>None</i>	Last <i>Oendorff</i>	2a. DATE OF DEATH Month <i>4</i>	Day <i>18</i>	Year <i>89</i>	2b. HOUR 5 ^{PM}					
3. SEX <i>Female</i>	4. RACE <i>Wht</i>	5. DATE OF BIRTH <i>10-7-89</i>		6. AGE (In years lost birthday) <i>79 yrs.</i>			IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Montgomery</i>								
8 WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>											
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San + Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Virginia</i>	13b. COUNTY <i>Fairfax</i>	13c. CITY OR TOWN <i>Falls Church</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>7250 Idylwood Rd.</i>								
14. FATHER'S NAME First <i>Edward</i>	Middle <i>Pennell</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Elsa</i>	Middle <i></i>	Last <i>Dorthea</i>	16. KIND OF BUSINESS OR INDUSTRY <i>Bonneau</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>262-44-0693</i>	17. INFORMANT <i>Hosp. Record</i>	Address									
18. CAUSE OF DEATH (Enter only one cause per line for Part I(a), (b), and (c))												
PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Myocardial insufficiency</i> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Hyperthyroidic heart disease</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Surgical Stress</i>												
(c) <i></i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
<i>Diabetes Mellitus & Adenocarcinoma of Endometrium with metastasis</i>												
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION <i>April 16, 1969</i>	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>RECTOCOLE & ADD. INCISIONS HEA</i>	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State							
22a. I certify that (I) (this hospital) attended the deceased from <i>April 15, 1969</i> , to <i>April 18, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 18, 1969</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Naor S. Stoehr M.D.</i>	DEGREE <i></i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>4-18-69</i>							
22d. PHYSICIAN'S NAME (Type) <i>Naor S. Stoehr</i>	22e. ADDRESS <i>Takoma Park Md</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>	23b. DATE <i>4/19/69</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	23d. LOCATION (City or Town) <i>Suitland</i>	(County) <i></i>	(State) <i>Maryland</i>							
24. FUNERAL DIRECTOR <i>Pearson's Funeral Home</i>	ADDRESS <i>Falls Church, Va</i>	25a. REC'D BY REGISTRAR <i>APR 23 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Pearson's</i>									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05702

05707

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, from the back of this page. Fill in page 2 with the State Dept. of Health prior to burial, cremation, or removal, and return, along with page 1, to the funeral director.

1. DECEASED NAME (Type or print)		First William	Middle Kemp	Last Pace	2a. DATE OF DEATH Month 4	Day 12	Year 69	2b. HOUR 6:20AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH 4-17-88		6. AGE (In years at death) 80		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MGH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) heating contractor		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER Washington Grove				
14. FATHER'S NAME First William		Middle H.	Last Pace	15. MOTHER'S MAIDEN NAME First Arietta Childs							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 217 32 0960		17 INFORMANT William H. Pace		70 Skyline Dr. Morristown, N.J.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Newmocid, Bronchic		DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Acute		DUE TO, OR AS A CONSEQUENCE OF (c) A.I.T.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 9125											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diverticulitis, Exfoliative Dermatitis, Cell Carcinoma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Bladder					
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE, BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 19 69 , to APR 12 1969 , that (I) (we) last saw the deceased alive on Apr. 11 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jack Schumacher		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 4-12-69					
22d. PHYSICIAN'S NAME (Type) Jack Schumacher M. D.		22e. ADDRESS Russell Ave. Gaithersburg, Maryland									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE April 14, 69		23c. NAME OF CEMETERY OR CREMATORIAL PARK Parklawn Mem. Park		23d. LOCATION (City or Town) Rockville Montg. Md.		(County) Montgomery		(State) Md.	
24. FUNERAL DIRECTOR Tyson Wheeler F. H. Rockville, Maryland		1331 Rockville Pike		25a. REC'D BY REGISTRAR DATE APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

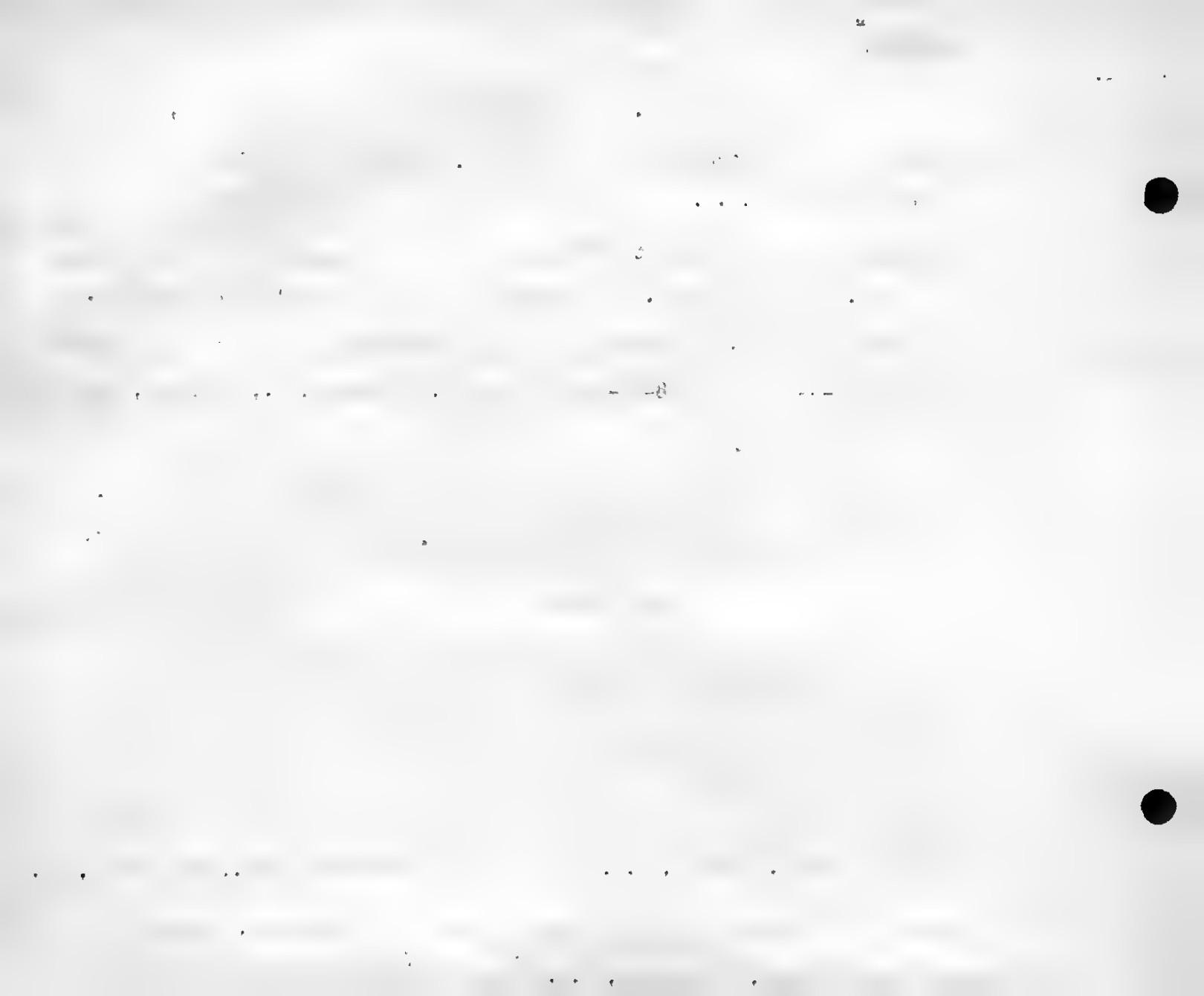
CERTIFICATE OF DEATH

05703

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages J and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First ALMA	Middle K.	Last PALSGROVE	2a. DATE OF DEATH Month APRIL Day 9, Year 1969		2b. HOUR 6 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Dec. 1, 1886		6. AGE (in years lost 1 today) 82 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens		12a. US/JAC RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Va.		12b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDSTRY At Home	
13a. US/JAC RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Va.		13b. CITY OR TOWN Arl.		13c. CITY OR TOWN Arlington		13d. INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4501 Arlington Blvd.	
14. FATHER'S NAME John		First P.	Middle Koerner	15. MOTHER'S MAIDEN NAME Margaret		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No ---		16b. SOCIAL SECURITY NO 570-09-7242 A	
17. INFORMANT John E. Palsgrove, Sr., Bethesda, Maryland								Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia 3 days									
(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 3 weeks									
(c) General arteriosclerosis 5 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	
22a. I certify that (I) (this hospital) attended the deceased from 1940 , 19, to 4/8/69 , 19 69 , that (I) (we) last saw the deceased alive on 4/8/69 , 19, and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death									
22b. SIGNATURE John E. Everett		22c. DEGREE ATTENDING PHYS		22d. MED. DIRECTOR <input checked="" type="checkbox"/>		22e. STAFF PHYS <input type="checkbox"/>		22f. DATE SIGNED 4/9/69	
22g. PHYSICIAN'S NAME (Type) John E. Everett, M.D.		22h. ADDRESS 9400 Connecticut Ave., Kensington, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Washington, D.C.		25a. ADDRESS 5130 Wisconsin Ave, NW		25b. REC'D BY REGISTRAR APR 14 1969		25c. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05709

05704

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial; cremation, or removal, and in any event, within 72 hours after death.

Cleared by medical examiner

1. DECEASED-NAME (Type or print)			First NELL	Middle MAE	Last PLAYER	2a. DATE OF DEATH Month 4 Day 13 Year 64	2b. HOUR 9 15 AM
3. SEX Female			4 RACE Caucasian	S. DATE OF BIRTH Nov. 3, 1907	6. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0
7a. BIRTHPLACE (State or foreign country) N. C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery County		
10. CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mellwood Farms			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Press Officer		12b KIND OF BUSINESS OR INDUSTRY U. S. Government
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Washington, D.C.		13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 730 24th St., N. W.			
14. FATHER'S NAME First Calvin			Middle Millard	Last Caudill	15. MOTHER'S MAIDEN NAME First Lucina	Middle Sirnetta	Last Myers
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT William B. Player 321 East 9th St. N.Y. N.Y. 10003	Address APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4127</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Cardiovascular Disease</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1</u> , 19 <u>69</u> , to <u>4-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.F. Cresswell, Jr.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) W.F. Cresswell, Jr.		22e. ADDRESS 2029 Q. St., NW Washington, D.C.					
23a. BUR. A. CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/69	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Maryland	(County)	(State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wisconsin Av., NW Washington, D.C.		ADDRESS		25a. REC'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05710

1 DECEASED NAME (Type or Print)	First Anna	Middle Barbara	Last PLUMMER	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 4	Day 5	Year 1969	2b HOUR 10 P.M.
3 SEX F	4 RACE W	5 DATE OF BIRTH Jan 3 1919	6 AGE (in years last birthday) 50 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) Penns	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Montgomery				2c. DATE PRONOUNCED DEAD Month April Day 6 Year 1969	2d HOUR 12 P.M.
10. CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4857 Battery Lane	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk	12b. KIND OF BUSINESS OR INDUSTRY C.I.A.					
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md	13b. CITY OR TOWN Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4857 Battery Lane, Bethesda				
14. FATHER'S NAME Franklin P Albright	15. MOTHER'S MAIDEN NAME Anna Barbara Dubbs							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. WWII	17. INFORMANT 200-10-9963 James E. Plummer	ADDRESS 4853 Cordell Ave. Bethesda, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Artery Insufficiency DUE TO, OR AS A CONSEQUENCE OF Coronary stenosis Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) Severe Coronary arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					years			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John G. Ball	EXAMINER'S NAME (Type) John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED April 7, 1969		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4-9-69	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d LOCATION (City or Town) Rockville, Mont.	(County) Md	(State)	23e ADDRESS Bethesda, Md		
24 FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS 7557 Wisconsin Ave Bethesda, Md	25a REC'D BY REGISTRAR APR 15 1969	25b. REGISTRAR'S SIGNATURE Charles Judge					
VR ATSM 5 10M REV 1/68								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05711

CERTIFICATE OF DEATH

05706

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JESSIE	Middle D.	Last POOLE	2a. DATE OF DEATH Month APRIL	Day 29	Year 69	2b HOUR 6 45 A.M.
3 SEX FEMALE	4. RACE Cauc.	5. DATE OF BIRTH August 5 1891			6 AGE (in years last birthday) 77 yrs.	IF UNDER 1 YEAR MONTHS 0	
7a BIRTHPLACE (State or foreign country) BETHESDA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH MONTGOMERY COUNTY			IF UNDER 24 HRS MONTHS 0	
10 CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE NURSING & CONV. CENTER			12a. JSJA. OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			
13a USUAL RESIDENCE (Where deceased lived, if institution Res. denke before admission) STATE MARYLAND	13b COUNTY MONTGOMERY	13c CTY OR TOWN BETHESDA	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 6013 BERSHIRE DRIVE	12b KIND OF BUSINESS OR INDUSTRY —		
14 FATHER'S NAME First HARRY	Middle C	Last Dean	15. MOTHER'S MAIDEN NAME First Lillian	Middle Mae	Last Brack		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-12-2222	17. INFORMANT A. Wilbur Russell Poole, Deau. Bethesda, MD	Address 6013 Berkshir				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 11419 Cardiac Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48h	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause Generalized arteriosclerosis						2014	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Parkinson Disease							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While □ Not while □ at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a I certify that (I) (this hospital) attended the deceased from 4/15 , 19 69 , to 4/29 , 19 69 , that (I) (we) last saw the deceased alive on 4/28/69 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald W. Barr, MD		DEGREE ATTENDING PHYS	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED 10401 Old Georgetown Rd BETHESDA		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 10401 Old Georgetown Rd BETHESDA					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-2-69	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d. LOCATION (City or Town) Rockville	County MONT. MD.		
24. FUNERAL DIRECTOR Robert A Pumphrey		25a. REC'D BY REGISTRAR DATE MAY 5 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05707

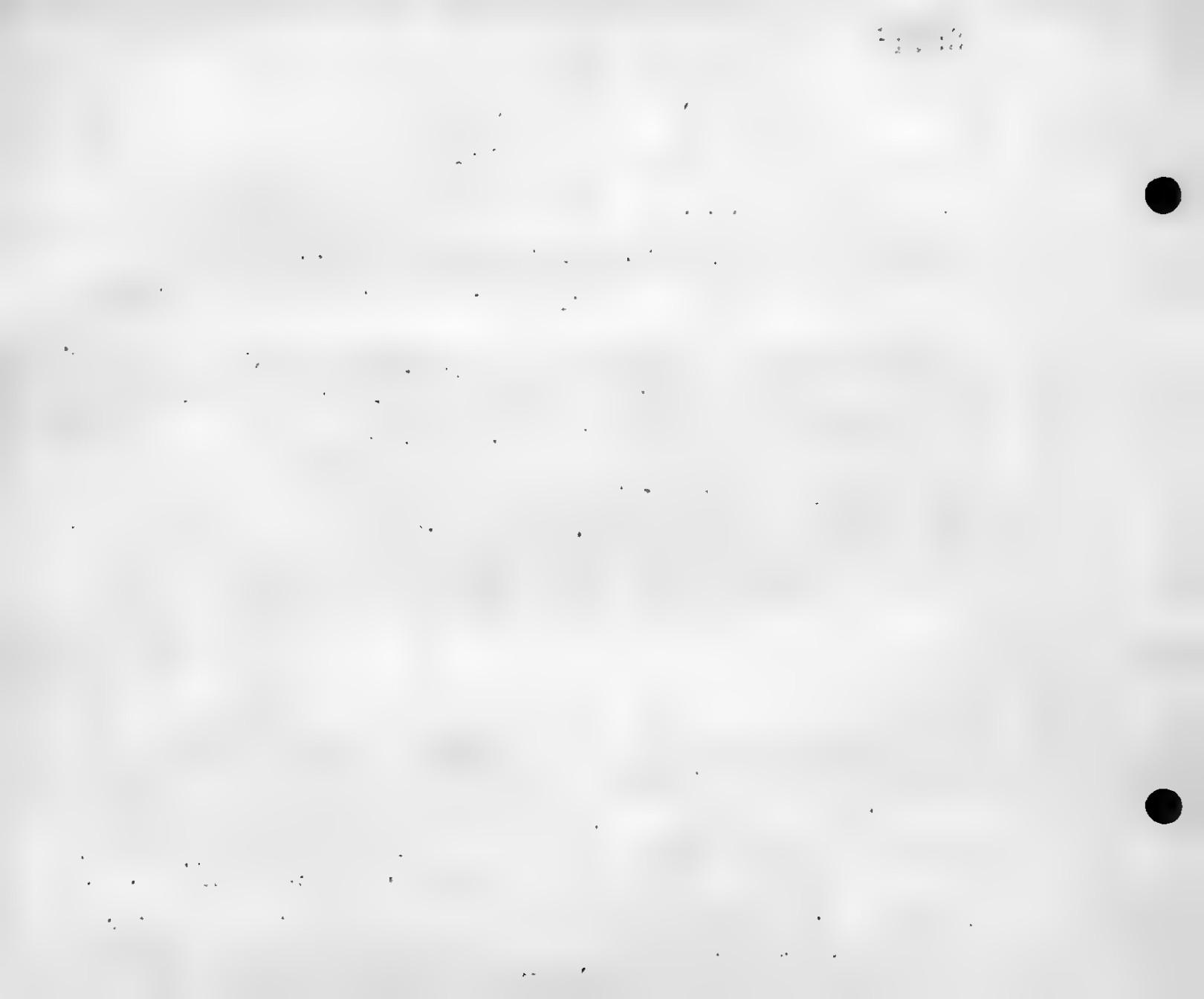
1 DECEASED NAME (Type or Print)	First <i>Ruby</i>	Middle <i>L.</i>	Last <i>PRINCE</i>	2a DATE KNOWN OF ESTI DEATH MATED <input type="checkbox"/>	Month <i>4 - 27</i>	Day <i>1969</i>	Year <i>3:57 P.M.</i>	2b HOUR <i>3:57 P.M.</i>					
3 SEX <i>F</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>11-23-19</i>	6 AGE (in years last birthday) <i>99 yrs</i>	7 IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	8 IF UNDER 24 HRS DAYS <input type="checkbox"/>	9 IF UNDER 24 HRS HOURS <input type="checkbox"/>	10 IF UNDER 24 HRS MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <i>4 - 27</i>	Day <i>1969</i>	Year <i>3:55 P.M.</i>	2d HOUR <i>3:55 P.M.</i>		
7a BIRTHPLACE (State or foreign country) <i>Md.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>									
10 CITY OR TOWN OF DEATH <i>Bethesda</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b KIND OF BUSINESS OR INDUSTRY <i></i>										
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>	13b COUNTY <i>Montgomery Bethesda</i>	13c CITY OR TOWN <i></i>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <i>8716 Hartsdale Ave.</i>									
14 FATHER'S NAME First <i>Odie</i>	Middle <i></i>	Last <i>Lynch</i>	15 MOTHER'S MAIDEN NAME First <i>Annie</i>	Middle <i>E.</i>	Last <i>Beall</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b SOCIAL SECURITY NO. (If yes give war or dates of service) <i>579-12-5475</i>	17. INFORMANT <i>Scwell Prince</i>	ADDRESS <i>8716 Hartsdale Av.</i>										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <i>884 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {							left side of brain. IMMEDIATE CAUSE (a) <i>massive-sub-dural and intra-cerebral hemorrhage.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Laceration of brain, due to trauma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fall at home</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Alcoholism</i>													
19a MEDICAL CERTIFICATION DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>HOUR</i>			21b TIME OF INJURY Month, Day, Year <i>8:30 AM 4/26 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>Fall out of bed -</i>								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>AT home</i>			21f LOCATION Street or R.F.D. No. <i>8716 HARTSDALE AV.</i>		City or Town <i>BETHESDA MONT MD</i>		County <i></i>	State <i></i>			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John G Ball</i>		EXAMINER'S NAME (Type) <i>John G Ball Md</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>April 28, 1969</i>			
23a BURIAL, CREMATION REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>5-1-69</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d LOCATION (City or Town) <i>Suitland</i>		(County) <i>Pr. Geo Md</i>		(State)			
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		ADDRESS <i>7557 Wisconsin Ave Bethesda, Md</i>		25a REC'D BY REGISTRAR <i>MAY 5 1969</i>		25b REGISTRAR'S SIGNATURE <i>William Young</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05708					
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH		Month	Doy	Year	2b. HOUR A.M.						
Patricia	Ann	Privette		April		7	1969	1969	8:05 M						
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female	Negro		19 August 1955			13 YRS.			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			Montgomery						
North Carolina	U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda	The Clinical Center, NIH					Student									
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		Eagle Rock Post Office						
North Carolina			Eagle Rock		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost							
Milton	D.	Privette		Alice		Mae			Burns						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.		17. INFORMANT			The Medical Record Address									
No	None					The Clinical Center, NIH Bethesda, Md. 20011									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fluid and Electrolyte Imbalance										3 Months					
DUE TO, OR AS A CONSEQUENCE OF (b) Uremic Syndrome										8 Months					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) Renal Insufficiency, Chronic										10 Years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
MEDICAL CERTIFICATION		19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 March, 1969, to 7 April, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 April 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE  M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 7 April 1969					
22d. PHYSICIAN'S NAME (Type) Alan Rider, M. D.										22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20011					
23a. BURIAL, CREMATION, REMOVAL (Specify) 		23b. DATE 4-11-69		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) RALEIGH N. CAROLINA		(County)		(State)				
24. FUNERAL DIRECTOR W.W. CHAMBERS		ADDRESS 1400 CHAPIN ST. N.W.					25a. RECEIVED BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE 						
WASH. D.C.							DATE								
VR A15 (4) 30M REV. 1/68															



FOR STATE
HEALTH DEPT.

within 24 hours after death any delay is
encountered in Item 18. Give Pages 1, 2 and 3 to
the Coroner's Office along with form Page

Items 18-22 Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-7-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05700

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR
MARGARET		LANSDALE		PUE	<input checked="" type="checkbox"/>		April 19, 1969 9 PM		
3. SEX Female	4. RACE White	S. DATE OF BIRTH 11/19/1915	6. AGE (In years last birthday) 53	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April		Day 19	Year 1969 9:10p 2d. HOUR
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Howard		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Highland			
14. FATHER'S NAME Richard		15. MOTHER'S MAIDEN NAME Lansdale		16. SOCIAL SECURITY NO. 579-16-6929		17. INFORMANT Richard F. Pue		ADDRESS Highland, Md.	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple external internal injuries DUE TO, OR AS A CONSEQUENCE OF (b) with exsanguination DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR 8:30 P.M. 4/19/1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased, driving, crossed midline in road & struck another auto head on.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. Route 108		City or Town Howard		County Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Peap</i>		EXAMINER'S NAME (Type) BELDEN R. PEAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED APRIL 19, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-22-69		23c. NAME OF CEMETERY OR CREMATORIAL St John Epis		23d. LOCATION (City or Town) Olney		(County) Mont. (State) Md.	
24. FUNERAL DIRECTOR Higinbottom-Stack		ADDRESS Ellicott City, Md.		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

卷之三

三、银行间市场的交易

REFERENCES

卷之三

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05710

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Frank	Middle (none)	Last Quaife	2a. DATE OF DEATH Month 4 Day 13 Year 69	2b. HOUR 9PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4-14-1893		6. AGE (in years last birthday) 75	IF UNDER 1 YEAR MONTHS YRS. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery	Md.
8 DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 300 McComas Ave Gas Station	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Owner	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? NO	13e. STREET AND NUMBER 11105 Waycross Way	
14. FATHER'S NAME First George	Middle Quaife	15. MOTHER'S MAIDEN NAME Mary	Middle Reeder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs L Newton	Address 11105 Waycross Way		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolyserna</i> 412X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ASCU II, Chronic decubital ulcer, carcinoma bladder.</i>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>12/18/64</i> , to <i>4/13/67</i> , that (I) (we) lost saw the deceased alive on <i>2/18/64</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Horace W Bernton MD</i>	DEGREE PHYS.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 16
22d. PHYSICIAN'S NAME (Type) Horace W Bernton MD	22e. ADDRESS 4743 Bradley Blvd Chevy Chase Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-17-69	23c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery	23d. LOCATION (City or Town) Streator, Ill.	(County)	(State)
24. FUNERAL DIRECTOR Robert A Pumphrey	ADDRESS 7557 Wisconsin Ave Bethesda, Md.	25a. REG'D. BY REGISTRAR APR 21 1969 DATE	25b. REGISTRAR'S SIGNATURE <i>Robert A Pumphrey</i>		

3190

(London)

1201242

1201242